





111

JOURNAL
OF
CUTANEOUS
(AND
(GENITO-URINARY) DISEASES *includ
Syphilis*

EDITED BY
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VOLUME V.

NEW YORK
WILLIAM WOOD & COMPANY
56 & 58 LAFAYETTE PLACE

1887

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JOURNAL
OF
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VOL. V.

JANUARY, 1887.

No. 1.

Original Communications.

NOTES OF CLINICAL CASES—ECZEMA ERYTHEMATOSUM AND
ERYTHEMA MULTIFORME.

THE chromo-lithographs which have appeared in this JOURNAL have, for the most part, represented rare and unusual forms of skin disease which are chiefly of interest to the specialist. The accompanying picture, illustrating the clinical aspect of two common skin affections, eczema erythematosum and erythema multiforme, will doubtless prove of more general interest.

The cases were treated at the New York Skin and Cancer Hospital, in the service of Dr. G. H. Fox, who has kindly furnished the photographs from which the picture is made.

CASE OF ECZEMA ERYTHEMATOSUM.

M. R., about 55 years of age. Patient at the New York Skin and Cancer Hospital.

The eruption, which was confined to the face, had existed for several years, getting nearly well at times. It was characterized by moderate thickening of the skin, a roughened pityriasic surface, and an intense pruritus, which was especially annoying upon the eyelids. The surface of the skin was dry, and there had been no exudation at any time in the course of the disease. The general treatment consisted mainly in re-

stricting the patient's diet to the most simple and digestible articles of food, and in keeping the kidneys and bowels acting freely. The local treatment was of a stimulating character. Frictions of green soap were employed for several days at a time, and then a mixture of oil of cade and olive oil (one part in five) was rubbed thoroughly into the skin. The improvement was slow, but the disease finally yielded to the above method of treatment.

CASE OF ERYTHEMA MULTIFORME.

Bridget M., æt. 40. Patient at the New York Skin and Cancer Hospital.

At date of admission, the eruption, which was of one week's duration, covered the face, trunk, and extremities. The lesions consisted of numerous elevated circular patches of a bright crimson color, tending to coalesce, and everywhere contrasting strongly with the intervening healthy skin. Many of the lesions, especially upon the lower extremities, presented a distinct purpuric centre. There was a moderate elevation of temperature, considerable malaise, and the patient complained of an intense burning sensation. The treatment consisted in the administration of a saline purgative at the outset, a restricted diet, and the frequent administration of ten-grain doses of the acetate of potash. In three days the erythema had almost disappeared, although the purpuric stains remained and gave the skin a mottled appearance. Ten days after admission she was discharged, her general condition being good, and the skin showing scarcely a trace of the former extensive eruption.

MUSCULAR SPASM OF THE DEEP URETHRA.

BY

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IT has been often advised that, in treating stricture of the pendulous urethra by internal urethrotomy, the sound which is to keep the cut open until cicatrization is accomplished shall not be allowed to pass beyond the sinuss of the bulb. This line of practice is based upon the well-known fact that, while the surgery of the pendulous urethra is comparatively an innocent matter so far as the life of the patient is concerned, the deep urethra is a locality full of danger. The urethral fever attending damage, great or small, done to the pendulous urethra is

commonly insignificant. The urethral fever attending disturbance of the deep urethra is more often severe, and in a certain proportion of cases lethal.

Now, although these facts are well known and the obvious deduction undisputed, that in cutting anterior stricture there is no excuse, so far as this operation is concerned, for passing any instrument beyond the sinus of the bulb, yet practically I believe that in nearly all, if not all, instances the first sound that enters the urethra after a stricture in its pendulous portion has been cut is made to enter the bladder on one plea or another, either to see whether there is any deeper stricture or to attempt to test the question of spasm. As a matter of habit, also, it is quite natural to let the first sound enter the bladder.

I am not, in this article, condemning the practice wholly. I have been accustomed to do it—to see whether or not the urethra was freely open throughout. My subsequent instrumentation to keep the stricture open is always confined to the limits of the urethra incised, or just beyond; but I raise the question whether in future it will not be better to leave the deep urethra untouched *in all cases* of anterior urethrotomy until the wound has healed—say until the third week—then to explore the deep urethra, as in an uncut case.

I make this suggestion just now, not so much for fear of serious urethral fever, but to test the question of urethral spasm, as will appear further on in my remarks. But that it also has a bearing in relation to the first point was only too clearly demonstrated to me during the past year by an experience which one of my house surgeons in Bellevue had with a common case of anterior urethrotomy done with Dr. Otis' instrument. The patient was a man of 41, with normal urine, save a little pus; no kidney disease. He had three tight points in the anterior urethra, but the deepest of them was only two (2) inches from the meatus. These anterior strictures were so small that the shaft of the Otis' instrument could not pass them, therefore the patient was first treated by having tunnelled steel instruments passed over a filiform bougie at intervals, commencing with No. 8 French tunnelled sound.

This treatment was kept up over a month, and the instruments were passed into the bladder. He never had a chill during this treatment or any considerable disturbance. No haste was used in his treatment, and when he had been dilated so that the Otis instrument could pass, he was cut upon this instrument to 35 French, the house surgeon considering that such an amount of incision was necessary. Thereupon a number 28 French (17 English) was passed once gently into the bladder to see that the way was open. Six hours later there was a chill followed by high temperature, and death thirty hours after the operation. No lesion was

found on autopsy. The kidneys were normal, with capsules slightly adherent. There had been suppression.

Here no violence was used. 17 English was easily made to enter the bladder, yet the result makes one feel that it would have been better in this case to have let the deep urethra alone until after the anterior urethra was well, and then to have gently explored it.

So much for a case of well-pronounced stricture. When the stricture is not well pronounced, when we have to deal with one of that class which allows so much diagnostic license to the surgeon, with a stricture of large calibre—here I have a suggestion to make, not so much in the interest of the patient as in the interest of science. In all such cases where the stricture is to be divided, not because it is itself small, not because there is gleet, but for some deep urethral difficulty, for some alleged deep urethral spasm due to the anterior contraction, for some distant reflex trouble believed to be due to the stricture of large calibre—in all such cases, I say, let the operator cut his stricture as large as he pleases, and refrain from even allowing the point of his sound to enter the triangular ligament, and then let us judge of the true value of anterior urethrotomy per se, notably for overcoming deep urethral spasm.

I have for a long time preferred the Otis instrument above all others for anterior urethrotomy. I have often performed his operation up to and even beyond his limits. I am perfectly willing to accept his limits as to sizes, not of what a normal urethra is, or even ought to be, but of what a pathological urethra may be safely raised to in its anterior part without deadly effect, and sometimes with advantage in the permanent cure of anterior stricture and to facilitate the cure of deep stricture. I consider it a limit better than any other that any one has devised, and up to which it is safe to go in selected cases. I do not believe that all case should be brought up to the standard, because I believe it unnecessary, and because so many patients, who have been thus freely cut, complain afterwards both of the appearance of the meatus and of the imperfection in the function of the urethra in expelling the last drops of urine after extensive cutting.

But the objective point of this paper is deep urethral spasm, its dependence upon anterior stricture of large calibre, and the possibility of overcoming this deep urethral spasm by simply cutting the anterior urethra and doing nothing to the deep urethra.

Muscular spasm of the deep urethra is an exceptionally common malady in all classes of people, but particularly in those of sensitive, high strung, nervous organization, particularly if such persons be of gouty or rheumatic constitution, and most especially in those who are sexually astray.

These are predisposing causes. The exciting causes are so numerous that I hesitate to begin to announce them, knowing that I shall leave very many forgotten. Among them may be cited any local neighboring irritation upon the surface of the urethra or within its calibre in the membranous urethra (stricture, foreign body), an enlarged or irritated prostate, or a mildly congestive bladder near the neck. All kidney inflammations: tumors, foreign bodies, irritations. Many troubles in the rectum: hæmorrhoids, fissure, cancer, impaction. The ingestion of certain substances: cantharides, turpentine, quinine, opium. The action of malarial influences (Thompson and B. Brodie), excesses or perversions of various emotions.

What surgeon has not witnessed spasmodic stricture attended by utter incapacity on the part of the patient to void his urine, due to modesty, shame, anxiety, fear, irritated mind (Cooper, Sebeaux).

Among the unusual cases, that of Tuffnell always stands prominent where a diagnosis of impassable deep stricture was made and preparations for cutting in the perineum commenced, when it was found that the patient had tape-worm. The operation was put off to allow the tape-worm to be driven out. This was done, and the stricture disappeared at once. Emmet had a case in which a necrosed coccyx occasioned urethral spasm, and Verneuil one in which abscess of the right seminal vesicle caused spasmodic stricture of an obstructive character. Dartigues¹ alludes to a number of remotely situated surgical lesions as occasioning retention through the agency of spasmodic stricture, such as forward luxation of the hip, mentioned by Hippocrates, Malgaigne, Cooper, and others—five cases after amputation of the thigh, three after ablation of the breast, one after breaking up an ankylosed elbow.

I have seen a most intense and persistent urethral spasm due to lumbar abscess, and cases almost without number in which the most varied kidney, bladder, prostatic, and seminal vesicular lesions caused urethral spasm. On one occasion, a youth came to me with a full bladder and absolute retention from urethral spasm, due to his having bathed his genitals in pure tincture of stavesacre for pediculi. His urethra had never known disease, and the simple passage of a catheter cured him for once and all; yet I feel quite confident that I might have cut this young gentleman's meatus to any extent, and that he would not have been cured. But if I had cut his meatus, and passed a sound into the bladder, he doubtless would have been cured, and I might, unwittingly, have ascribed the cure to the cut rather than to the passage of the instrument through the membranous urethra, to which latter act it undoubtedly would have been due.

¹ Thèse de doctorat, Paris, 1873.

Under the very happy title *Urethrismus*—a term, I believe, coined by Dr. Otis—F. H. Davenport reports¹ the case of an old man who had had all the evidences of deep urethral obstruction for ten years, and who was relieved at once, and permanently, by a single passage of a silver catheter. If, in this case, the meatus had been first freely incised, and a large sound then passed into the bladder, the cure would surely have been ascribed to the cutting, although, as the case really turned out, the cutting would have been innocent of all share in the credit of cure.

And this occasions my suggestion, Will it not be well in future for those of us who are investigating this subject, when we think we have a case where anterior stricture of large calibre is causing either urethral spasm, obscure bladder trouble, or other reflex disturbance, will it not be well for us, I say, if we so believe, or when we so believe, to confine our treatment solely and entirely to the anterior stricture of large calibre, and not to touch the deep urethra until our hypothesis is proved or our assumption shattered?

When there are so many causes for deep urethral spasm, I cannot say that anterior stricture of large calibre is not or may not be one of them; but I certainly may express a belief that it is a very uncommon cause. A tight pin-hole meatus, a positive small anterior stricture is one thing, and a thing surely capable of exciting deep urethral spasm and vesical complications; but if a stricture of large calibre can cause deep urethral spasm, it must be a very rare circumstance, since I have been for several years on the lookout for such a case, and I have not found it.

I believe when anterior stricture of large calibre exists coincidently with deep urethral spasm, the spasm being due to another cause, that in such cases operation upon the stricture usually does good for a time, but for a time only, and I think that sometimes the good may be due to moral effect rather than to the operation. This is particularly true in the case of neurotic patients who suffer from deep urethral spasm, but even here I think the cutting might miscarry if the deep urethra were left unmolested, because I incline to a belief that it is the over-distention of the membranous urethra which does the good, and not the cutting of the anterior urethra. I believe I have seen many instances of this.

I do not deny that anterior urethral irritation, with or without stricture of small calibre, may cause deep urethral spasm, for I have often seen this occur—but that simple, unirritated stricture of large calibre causes it, acting alone, I do not yet believe, because I have not seen it. In many cases of anterior urethral tightness, where there has been deep urethral trouble, I have seen great temporary advantage follow an inter-

¹ Boston Medical and Surgical Journal, May 12, 1881, p. 444.

nal urethrotomy, but the advantage in my experience has been temporary—so far as deep urethral spasm and neurotic conditions are concerned—unless there was also some deep urethral trouble, as well as the anterior points of tightness, and unless the former was removed by treatment.

This good temporary influence, I think, is something similar to a faith-cure effect—and surely one may honestly demand an overwhelming amount of testimony to be convincing on a point so obscure as the relief of deep urethral spasm by cutting unirritating points of physiological narrowing in the anterior urethra, when equally good effects are alleged to be produced by an influence so unpardonable as that called hypnotic suggestion.

During the current year, June, 1886, Dr. G. Ramey reported in the *Bulletin de la Société de Biologie*¹ the case of a young man who, for five years, had suffered functional symptoms, which were ascribed to urethral stricture. He was a nervous person, but he never had had gonorrhœa or a wound of the urethra.

His symptoms became so severe that, in November, 1885, a surgeon felt obliged to perform internal urethrotomy upon him (“se crut obligé de lui pratiquer d’urgence l’uréthrotomie interne”). But the operation brought no comfort to the patient’s urethro-vesical condition. Then, on account of clear signs of a *nevrosism*, spasmodic contraction of the membranous urethra was thought of, and by the aid of “la suggestion hypnotique,” this patient was radically cured at the second sitting of all his urinary troubles, and the cure continued permanent after five months.

In my rather earnest search for a case which might prove to me that anterior stricture of large calibre was capable alone of causing the symptoms of deep urethral trouble, I have recently encountered two cases which at first almost persuaded me, but I became undeceived. They are so nearly alike that the recital of one will suffice.

A healthy Vermont farmer came to New York this autumn, referred to me as a case of deep stricture. The patient urinated often eleven times a day, had deep urethral pain and distress, pus in his urine, a persistent gleet. Once a month, or thereabout, he used a short, straight metallic sound two and one-half inches long. This he pushed into his urethra, and alleged that thereafter for a considerable time he lost a certain pain that he had under the frænum, and urinated less often and with a larger stream. I now believe that this may have been due to moral effect. It immediately occurred to me, here is the case for which I have been searching; I will examine him, and if I find no deep urethral trouble, I will cut him freely in front, and see if he will get well

¹ It is quoted in the *Ann. des Mal. des Org. Gén.-Urinaires*, Oct., 1886, p. 623.

when I leave the deep urethra alone. So I tested him with the urethrometer, and found that while the sinus of the bulb easily allowed the instrument to be screwed up to 37, at two and one-half inches, I had to reduce it to 27, and at one inch a little lower. I then took a 15 (French) instrument, and passed it easily into the bladder. It was not grasped. The patient's stream had been quite small, almost in drops.

On the same day, in the afternoon, I cut the anterior urethra fully up to the Otis standard—38 French. The patient had not passed water since my exploration in the morning. I introduced no instrument beyond the sinus of the bulb, at the time of cutting, yet immediately thereafter my patient urinated freely in a stream which delighted him—and, I confess it, myself. I treated this man by keeping open the cut surfaces, but not attempting to pass an instrument into his bladder, and I found in a few days that, although No. 36 could easily pass to the triangular ligament, my patient again was urinating in a small stream, with effort, and frequently. Then I recognized that it had been my explorative passage of the No. 15 into his bladder and through the membranous urethra on the day of operation which had done the good, rather than my subsequent anterior cutting up to thirty-eight. I explored and found a very moderate but positive stricture at the bulbo-membranous junction, and dilating this, I gave my patient comfort, and, I believe, a cure.

This case, and its fellow, has instructed me, and I believe it justifies me in making the suggestion to those who wish to study the effect of wide division of anterior stricture of large calibre upon deep urethral troubles, that they should study this matter by confining their attention solely to the anterior urethra, and see what results come from such a course.

DECEMBER 1, 1886. 1 Park ave., New York City.

GONORRHOEAL INFECTION IN WOMEN.

DR. E. SCHWARZ, in the *Sammlung Klin. Vorträge*, No. 279, calls attention to the very important relation of many affections of the uterus, ovaries, Fallopian tubes, and the peritoneum with previous gonorrhoeal infection in women, as shown by the researches of Nöggerath, Sänger, and others. The paper is a very excellent one, but too extensive to receive adequate attention within the limits of our space. He strongly urges the physician to treat gonorrhoea thoroughly in women, and not to leave cases to themselves, as is so often done, with the great probability of developing some of the serious complications and consequences above noted.

REMARKS ON, AND QUERIES AS TO RELATIVE FREQUENCY OF
PATHOLOGICAL CHANGES IN MOLES AND OTHER TUMORS ON
FACE AND HEAD.¹

BY

SAMUEL SHERWELL, M.D.

THE history, etiology, and treatment of the class of cases for which this somewhat labored title stands, is so slightly, and I might almost say contemptuously, referred to in works on dermatology, that, in view of their, to my mind, relative importance and frequency, as it would appear in my own clinics and private practice, I have been led to, firstly, great respect for them, and secondly, to an increasing attention to the subject.

Convinced as I am that my experience cannot be singular, I have been led to look up the records of one of my largest clinics, that of the Skin and Throat Department at Brooklyn Eye and Ear Hospital, and find that, in the eighteen months just passed, there have been recorded forty-seven cases suffering from neoplastic and hypertrophic growths, and retention and other cysts. Out of this whole number, thirty-six of the tumors had for site the face and head, some two or at most three (it is not clear in notes) of them on neck.

Seventeen of these cases were classed as epitheliomatous, their clinical history and appearance seeming to bear out that diagnosis.

There appears some chance here for error, as possibly some one or two of these might well have been sarcomas, no microscopical examination as a rule is instituted; the evident fact of malignancy or well-grounded fear of such is enough to cause advice as to ablation. Others, however, in same region and elsewhere, were diagnosed as sarcomas.

Eleven cases then only, as will be noted, out of the whole number of forty-seven presenting themselves for advice, were distributed on body and limbs.

Memory and experience as to my other clinics and private practice bearing out, measurably at least, the same statistics, I have brought myself to ask if there can be any rational explanation of the fact of this relative excess of new formations in the regions indicated, for I cannot, as aforesaid, believe my experience to be unique. Still we do not find it

¹ Read before the Tenth Annual Meeting of the American Dermatological Association.

laid down as an axiom in treatises on dermatology to beware of growths on the face, but I yet think that most skin men must come to somewhat the conclusion I have arrived at, though possibly not in same degree.

Personally, I have been unable to formulate any explanation absolutely satisfactory to myself for these phenomena.

We all know that dermatologists are, as a rule, more generally applied to for cosmetic relief than the general surgeon; that might be accepted as a partial, a very partial explanation, when we consider that most tumors of the superficies, whether concealed by clothing or patent to observation, come under our notice first or last, the patient hoping and believing that more speedy and less painful means of relief may result from such special service, and dreading the knife of the general operator. Besides, we have ourselves all been "a little lower than the angels," at one time, viz., "when general medical men;" and I think my own experience in that somewhat lengthy period will bear out that of my present, as far as memory serves. Perhaps that of others will do the same, as to the approach to truth of the present statistical exhibit.

It might be urged that atmospheric changes and exposure to them, by causing rapid circulatory changes and what not, in exposed and prominent parts of the unclothed surface might lead to the formation of neoplasms, and destructive activity in those present. If that be so, why should not these telangiectatic deformities, *nævi* and such, oftener suffer degenerative changes? We all can see the violent alterations of color, and the alternate textural shrinking and distention produced in them by excessive alterations of heat and cold, as well as by emotional causes; yet, save in one case of extensive *nævus verrucosus*, I have never seen malignant action, or what simulated such, set in, and would ask further if any member of the Association has, in the cases, we will say, of *nævus flammeus* or port-wine mark.

While on this subject, I take occasion to protest against the application of the term *nævus*, as applied to the ordinary pigmented or lipomatous or fibrous mole; I am glad to see that Robinson does so in his excellent treatise; it is in my opinion a decided misnomer, for the reasons there given, and my opinion, or one of them, for their pathological activity in age is, that it is caused by imperfect, irregular, and aborted nutrition, and that the original and focal morbid action comes from sulci leading into their depths, making almost crypts or cysts lined and covered with epithelial masses which there become degenerate, and factors of irritation.

Mechanical irritations of the parts indicated could probably be adduced, too, as a reason for their frequency and malignant tissue alteration, but there are many other parts of the body, it would seem, equally or

more exposed to these accidents than the carefully guarded face, as for instance the hands, nates, waist, and neck; the two latter from constant friction of clothing, as well as other causes.

Moles and other small fibroid tumors are sufficiently common in these parts of the body, but it would appear, by the statistics given and by other experience of the writer, that the ratio of further and destructive pathological activity is much less in them, and in all other parts of the body together, than on the head and face.

So marked does this elective action appear to me that, frequently when a person of maturer years becomes my patient for whatsoever cause, having such small tumors as moles, verrucous growths, etc., etc., on the face, temporal region, or brow (for these in my experience are the seats specially inimical), I am in the habit of advising him or her to watch for any sign of change in them; as for instance, rapidly increasing growth, the ordinary signs of irritation, and more especially of formation of a scab resulting from some slight injury, as of a scratch or blow, and more particularly if this should result in continuous formation of the same slight scab, with constant increase in size of same. Under the occurrence of those circumstances happening, I feel justified in telling him that he ought thereupon to consult some good surgeon, whether dermatologist or not, and if the selected medical man advise ablation, to undergo the operation immediately, for reasons that I need not dwell on further.

It may not be out of place to give my opinion of what constitutes the danger line as to boundaries on face. I cannot offer any further statistics than I have given, the task of looking through all my clinical histories and often imperfect records of private practice would be great, and probably would carry no more weight than this simple expression of opinion. The field most electively inimical to presence and formation of these morbid growths, and what I have and will call degenerative activity in those already present, may be bounded thus:

A quadrangle just taking in lower lip and corners of mouth, extended back to the ears on both sides, vertical lines extending upwards to about an inch above supra-orbital ridge, united by another horizontal line.

Of the space thus included, the vicinity of eyelids and bridge of nose seems in my experience the most usual for these growths and their consequences, even when the frequency of epithelioma of the lower lip is taken into consideration.

The most rational way of solution or accounting for the frequency of these growths in the sites mentioned is probably, that it is after all due to the extent, nature, and abundance of circulatory nutrition, which must favor hyperplasia in these well-supplied parts. We all know and

see how rapidly wounds and other lesions of the face heal after operation and accident.

If, however, we accept the above-mentioned hypothesis, why then should those errors of the capillary system, such as *nævi*, not oftener degenerate, as I am convinced they do not; it is a question I cannot answer, and would like explained. I have operated, too, in various ways upon many of these deformities, sometimes with negative, sometimes beneficial results, nothing more than slight keloidal change has ever resulted to my knowledge, and have irritated them immensely in so doing.

I have operated on these growths in most of the usual methods, but have finally come to the conclusion that in most, especially when malignancy is either present or feared, the combination of Volkman's curette, followed by potential canterry, both freely used, is the most efficient and easiest procedure. Of all escharotics I prefer the liq. hydrarg. nitratis.

"DIPHThEROID CHANCRE."

BY

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Chicago, Ill.

DIPHThEROID chancre has been described as one of the anomalous appearances of the initial lesion of syphilis by Dr. P. A. Morrow¹ and Dr. R. W. Taylor.² It has been my fortune to have met with three cases of this rare form of diphtheroid exudation accompanying venereal sores; to have watched the formation of this false membrane from its inception; to have seen it disappear; and, subsequently, in two of the cases, to have pursued an antisiphilitic treatment, which treatment the patients still faithfully adhere to. The third case, which, unfortunately, was my first, was lost sight of before the disappearance of the membrane.

The following are the histories of the three cases, as found in my notebook:

CASE I.—H. E. G., American, age 38, married, travelling salesman,

¹ "On a Rare Form of Initial Lesion, Diphtheroid of the Glans Penis"—report of a case with remarks. P. A. Morrow, M.D. Archives Dermatology, N. Y., 1876, vol. ii., p. 303.

² "Pathology and Treatment of Venereal Diseases," by Freeman J. Bumstead, M.D., LL.D., and R. W. Taylor, A.M., M.D. Fifth edition, 1883, p. 490.

applied for treatment on August 8, 1882, for six venereal sores on glans penis, circling the corona. Stated that last suspicious intercourse had taken place five days previous to the appearance of the ulcers, and that the ulcers had been noticed by him four days prior to his visit to me. Denied having ever had any venereal disease before, with the exception of an attack of gonorrhœa during the winter of 1880-81, and stated that he recovered from this in about six weeks. He was greatly worried over these chancroids, as, from history and appearance, I diagnosed them, and requested that I burn them. This I proceeded to do with nitric acid. Dressed them with iodoform and absorbent cotton, and told him to call next day.

August 9. Discharge from chancroids is quite profuse. Applied same dressing.

August 12. Chancroids but slightly, if any, diminished in size. Noticed for the first time some shreds of a dirty-white tissue adhering to glans penis, adjacent to chancroids. Thinking probably that the acid from first application had destroyed more tissue than was intended, I paid no further attention to the matter. Upon earnest solicitation of patient, I again burnt the sores with nitric acid, and dressed with iodoform.

August 14. Upon removing the cotton, what was my astonishment to see that this dirty-white membrane had extended until it covered, not only the chancroids, but at least one-half of the glans penis on its dorsal surface! It was not in an unbroken form, but little islands of unengulfed tissue were noticeable. When I proceeded to remove it, I found it quite intimately adherent to the subjacent glans, and when finally removed, the glans was studded with oozing and bleeding points. The membrane was tough, leathery, and greasy, dirty-white in its appearance, and about one line in thickness. It was most certainly an anomalous form of lesion to me; but, as my patient took it all as a matter of course, I was not compelled to attempt an explanation. I simply dressed the entire surface with iodoform.

August 20. Patient has been away from the city since last date. States that this diphtheroid membrane re-formed very shortly after his last visit, and that he has been treating it simply by washing it twice daily and applying iodoform. I now find that the membrane covers a larger area than at last visit, is of the same character, and as intimately adherent as previously. Same treatment.

August 23. Membrane still persistent, but less of the glans covered by it.

August 26. Diphtheroid membrane still present. Presumably, Mr. G. was dissatisfied, as I have not seen him from that day to this.

CASE II.—Samuel A. M., English, age 23, single, journalist, ap-

plied for treatment on April 2, 1885. I find in my note-book the following: "Case of chancroids discovered first last night. Suspicious intercourse three days ago. One large chancroid, preputial, near frænum, covered with yellowish pus; three small ones on glans penis. Treatment: Burnt with nitric acid and dressed with iodoform. Cleanliness." It seemed such a clear case of soft chancres that I did not inquire into the history as carefully as I might, and simply elicited the information that patient had had a chancre, said to be soft, in New York City, in 1883, and an attack of gonorrhœa in 1884, the latter of which he had never completely recovered from, having at times recurrent attacks of an urethral discharge.

April 4. Chancroids healing. Urethritis developed. Prescribed balsam copaiba.

April 7. Small chancroids spreading. Burnt them all with nitric acid. Ordered strict cleanliness and iodoform.

April 11. Chancroids more healthy in appearance.

April 13. All cicatrized but larger one, and that diminishing rapidly in size.

April 18. Chancroids cicatrized, but urethritis persists. Prescribed zinc and lead injection.

April 23. Patient called, worried at the appearance of the chancroidal cicatrices. These cicatrices were very highly colored, of a dark-red hue, and neither elevated nor depressed.

May 12. Mr. M. returns with from six to eight small moist patches dotted around the corona, covered with a dirty-white membrane that extended beyond these patches, and which, upon removal, disclosed an excoriated surface. He states that this membrane began to form five days ago. I now recognized the similarity to Case I., ordered calomel as a dusting powder, and prescribed a wash of lead, alcohol, and water.

May 15. The condition of affairs cannot be better described than from quoting from Dr. Morrow's article heretofore referred to: "The anterior four-fifths of the glans penis was covered with a glistening, grayish-white coating of a leathery consistence, simulating in all its physical characteristics a diphtheritic exudation. This coating was of uniform thickness, raised about two lines above the healthy mucous membrane, and covered the entire surface of the glans, except a narrow zone embracing the corona. The edges of the coating were abruptly raised, and the line of demarcation between its border and the healthy tissue was distinct, and unmasked by an inflammatory areola. This appearance was suggestive of a white membranous hood drawn over the head of the penis, with a slit-like opening for the meatus in front. So evenly and smoothly was it moulded over the glans that the contour was perfectly

preserved. A sensation of a smooth, greasy feel was communicated to the finger passed over the surface. There was absolutely no erosion; its epithelial coat seemed to be continuous with that of the healthy mucous membrane, which limited its circumferential border above. Its base was supple, with no trace of induration. Its surface was moist and glistening, with no appreciable secretion. It was intimately adherent, and could not be detached from the tissues which supported it without leaving a bleeding base."

With considerable difficulty, I removed the greater part of this false membrane, and dressed the raw, oozing surface beneath with iodoform.

May 19. Diphtheroid membrane diminished in extent.

June 1. The false membrane has entirely disappeared.

August 15. Two ulcerative patches discovered on soft palate. Placed patient on mixed treatment.

The ulcerated patches disappeared readily, but the congestion and soreness of the fauces persisted to September 18, on which date no symptom whatever remained. The mixed treatment was, however, continued to December 1. Patient was then placed upon a steady dose of pil. hydrarg. bichlor., gr. $\frac{1}{12}$, four a day, and, with an intermission of three months only during the past summer, has been and is now taking his regulation dose.

CASE III.—Chas. M. F., American, age 23, single, musician, applied for treatment on September 10, 1885, with five venereal sores of four days' duration on glans and inner aspect of prepuce. No history of previous venereal disease. His last act of intercourse had taken place ten days before he discovered the sores. These sores were not at all indurated, were superficial, and covered with yellowish pus, having all the appearance of chancrels. I burnt them with nitric acid, and applied iodoform.

September 17. The ulcerated surfaces having grown smaller, on account of the patient's dislike to the odor of the iodoform, I changed the dressing to calomel.

September 21. Ulceration has recommenced, and pus is forming rapidly. Changed dressing again to iodoform after having again burnt the sores with nitric acid.

September 24. Much better.

September 26. Sores cicatrized, it having been twenty days since they were first noticed.

From November 3 to December 3, 1885, I treated Mr. F. for an attack of gonorrhœa with complication of epididymitis. April 19, 1886, seven months after the appearance of these supposed chancrels, Mr. F. came to my office to consult me for an alopecia arcata of two months'

duration, and also for three mucous patches on glans penis with a venereal wart thrown in. The mucous patches had been noticed by him three weeks previous. Patient was placed on potass. iod. grs. x. t. i. d., with application to the scalp of an ointment of hydrarg. bichlor. grs. ij. to $\frac{3}{4}$ i.

April 23. The mucous patches on glans were covered with this same glistening white membrane heretofore described, which, upon removal, disclosed the familiar excoriated surface. Iodoform was applied, and the potash ordered increased by grs. iij. a day.

April 26. This diphtheroid membrane had invaded new tissue, and I believed I was to have a repetition of Case II.

April 29, however, I find my notes to read: "Leathery formation gone, ulcers healed; potash grs. xx. t. i. d."

May 10. The treatment was changed to the mixed treatment, potass. iod., grs. xxv.; hydrarg. biniod., gr. $\frac{1}{12}$, t. i. d. I continued this treatment to June 5, when the patient's hair being as thick as ever, I changed his medicine to pil. hydrarg. bichlor. gr. $\frac{1}{12}$, four a day. Mr. F. has persisted faithfully in swallowing his four pills a day, and has had no sign nor symptom of syphilis since.

In Case I. the diphtheroid membrane developed subsequently to the burning of the venereal ulcers; consequently it was not the initial lesion *per se*; although, had the patient come to me with the membrane already present, I might easily have been persuaded into the belief that it was an initial lesion. In Case II., whether or not the sores I burnt on April 2, 1885, were true chancres or mucous patches ulcerated, still it is positive that the diphtheroid membrane, developed on May 12, was not the *initial lesion*. This patient had not had intercourse since April 2, according to his own statement—and from my knowledge of him I believe this statement perfectly trustworthy. It is possible, of course, that the syphilitic infection occurred prior to April 2, and that the sores burnt by me on that day were *chancroids*, and that the lesion of syphilis did not make its appearance until May 12, under the guise of this diphtheroid membrane. This, I say, is possible, but not probable, when we take into consideration the history of Case III. In Case III., Mr. F., on September 10, 1885, had been treated by me for what I supposed to be soft chancres or chancroids. No internal medication whatever was given him, there being no history of any previous venereal disease. Some six months after the appearance of these sores, his hair began to come out in patches, constituting a true *alopecia areata*. One month following that, mucous patches manifested themselves on the glans penis, and I then saw him again. Following these mucous patches, and whilst they were still present, this same, familiar then to me, diphtheroid membrane began

to develop. There could be no doubt in this case; Mr. F. was positively suffering from secondary syphilis. Treatment was instituted for that, and in a week the membrane had melted away.

What conclusion are we compelled to by these facts? None but one, that this diphtheroid membrane is not the initial lesion of syphilis, but *one of the rare secondary symptoms.*

In none of the reported cases do I find that the patients were under treatment when the membrane developed, and, therefore, I believe from my knowledge of my own cases that, if the truth could have been known, a history of previous venereal disease would always have been obtained. In the November, 1886, number of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, in the report of the "Society Transactions," is found the report of a case of "diphtheroid chancre," by Dr. Taylor. In this case, no absolute history could be obtained, owing to the dirty and careless habits of the patient. However, it is very probable that the patient's entire family, including his mother, his sister, his brother, and his nephew, were suffering from secondary and tertiary syphilis; and what more probable, then, than that Dr. Taylor's patient had contracted syphilis at least months before, had paid no attention to it, owing to his dirty and careless habits, possibly had not even been aware of it, and now had developed this diphtheroid membrane as one of the secondaries.

I believe that in Cases I. and II. I mistook irritated and ulcerated mucous patches for chancreoids, and that, which is evident, I diagnosed in Case III. a true chancre as a chancreoid. Mr. G., Case I., without any doubt in my mind, either intentionally told me an untruth when he denied previous venereal disease, accompanied by a sore, or was unaware of it himself.¹ That he was then suffering from secondary manifestations I consider more than probable when we take into consideration the histories of Cases II. and III. Mr. M., Case II., when he first applied for treatment on April 2, 1885, was either suffering from late secondary manifestations, developed from the infection in New York City in 1883,

¹ That it is possible for a patient to have syphilis and not know it was fully demonstrated to me during the summer of 1885. I then had under treatment a case of apoplexy, which, for various reasons, I believed due to syphilis. This diagnosis was concurred in by Drs. Lyman and Parkes of this city. Although the patient was informed that probably his life depended on the truth, he strenuously denied, at least to his own knowledge, having ever had syphilis. He was then placed on expectant plan of treatment. When on the verge of the grave, going from bad to worse, the treatment was changed to anti-syphilitic—iodide of potash—rapidly pushed. On a daily-dose of one hundred grains he began to improve. Potash was finally given in the enormous quantity of *three hundred grains per diem*, and in three months the apoplectic was to all external appearances the same man as previous to his stroke.

or the sore burnt by me on April 2, 1885, was a true chancre, without any noticeable induration, and on May 12 was followed by very early secondary symptoms. My impression is, that the first of these suppositions is the correct one, namely, that the sore of 1883 was a chancre. In Case III., there was and is no doubt. Mr. F., at the time that the diphtheroid membrane developed, had also other secondary symptoms, and, when placed on appropriate treatment, the diphtheroid membrane melted away with most gratifying rapidity. Arguing from this, had Cases I. and II. been placed on the same treatment, what most probably would have been the result?

To conclude: The so-called anomalous lesion, "diphtheroid chancre," is not an initial lesion, but a *secondary symptom*, and, could the true history be always obtained, there would be no doubt in the diagnosis; and the appropriate treatment is either iodide of potash alone or iodide of potash combined with mercury, the so-called *mixed treatment*.

OPERA HOUSE BUILDING.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY

167TH REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. ROBINSON presented a case of

ECZEMA

of peculiar appearance and method of extension. The patient was a lady who for many years had suffered from attacks of gout. At the age of thirty she had an eczema upon the right leg, extending from the knee downward, which lasted eighteen years, was almost constantly treated and finally cured, and she remained free from the disease for some months.

The present eruption began at the angles of the mouth, and was attended with fissures, moisture, itching, and all the features of an eczema. There were inflammatory papules, small vesicles lasting a week or two, and the lesions were acutely inflammatory in character. The eruption has slowly enlarged by peripheral extension, and now occupies the lower portion of the face, the neck, the upper portion of the chest, and extends in a narrow band across the shoulders. The limitation of the eruption is sharply defined, and the latter portion is covered with scales and has much the appearance of a psoriasis.

Four years ago, the patient had an acute attack of gout, and the eruption entirely disappeared. She was at that time treated with Hosford's Acid Phosphate and appropriate diet. Soon afterward the eruption returned upon the face, and

soon took on this irregular and unusual method of extension, with sharp limitation. The itching has always been intense.

DR. MORROW said that the case was rare and unique as regarded its configuration and mode of development. He had seen a number of cases of gouty disease of the skin, but the eruption was, as a rule, located below the knee. The aspect of the lesion was like, and at the same time unlike, a psoriasis, but he should regard it as an eczema.

DR. SHERWOOD said he was inclined to think that the psoriatic element predominated, and that he should call it an eczematous psoriasis in preference to a psoriatic eczema. Gouty leg, in his experience, did not resemble the condition here presented, and there was more infiltration of the skin than is usually found in a psoriasis. He should treat the case as one of psoriasis and thought the results of treatment would present points of interest.

DR. KEYES said that the teachings of Bazin, who might be called the father of the arthritic and gouty skin affections, showed the lesions to be multiple, itchy, rarely vesicular, with a tendency to develop about the natural orifices of the body, found mostly in the central line of the body, and of nummular form and distribution. As to treatment, he would suggest attacking the line of advance (as it had been observed to increase slowly from the periphery) with the nitrate of silver, carbolic acid injection, or some such means.

DR. STURGIS thought the case of interest from its mode of development, commencing at the mouth and invading the other parts gradually, from above downward, skipping over and leaving regions of healthy skin. He thought local treatment does comparatively little good in these cases. He had known a course of the Carlsbad waters to be followed by good results.

DR. FOX did not think the eruption could be regarded as a psoriasis. He would no more expect to find a psoriasis restricted and limited to one spot or one region of the body than he would expect to find a scarlatina confined to one arm.

He would expect benefit from local applications because there was not much inflammatory action present.

DR. PIFFARD asked if lichen ruber had been excluded, as at the first glance it had looked to him not unlike some rare cases of this disease which he had encountered.

DR. ALLEN said he regarded it as an eczema, because upon scraping the scaly patch with a curette, it had not given the characteristic bleeding points, and other appearances of psoriasis, but rather those of eczema.

DR. TAYLOR said that, in elderly persons, especially in women with delicate skin, the later stages of chronic eczema present an infiltration and scaling greatly resembling psoriasis, and that the case under discussion would be called by many a psoriasis, were the antecedent history not known.

DR. ROBINSON thought there could be no doubt about the diagnosis of eczema, when we remembered the previous attack of eczema, which was undoubted; the marked pruritus which had always existed; the sharp limitation of the patch; the inflammatory margin, and, as had been referred to, the changes noted upon scraping the scaly patch. He had taken no pains to exclude lichen ruber, as none were necessary, as this disease had not suggested itself to him from any case he had ever seen, or from the description given of it by Hebra.

All local treatment had made the disease worse and caused it to spread, and he agreed with Dr. Sturgis in regard to the inefficiency of local measures. Rose ointment is the only local application which the patient has been able to use. Since her attack of gout she has taken lithiated potash and soda, and milk and Vichy. Lithiates, colchicum, and such drugs improve the condition of the part, probably by their constitutional effects upon the gouty condition. He believes that if he would produce the eruption on the legs, the face could be cured in all probability.

DR. MORROW had seen the good effects of transpositive or substitutive treatment in a patient with eczema of the scrotum and anus. When he presented himself for examination, the legs had a peculiar pigmented appearance, in well-defined squares, and he learned that the patient had been in the habit of constantly irritating his legs by means of plasters to keep down the eruption upon the genitals. He found that all the intense symptoms around the anus were compara-

tively relieved by thus producing a counter-irritation. According to the patient's statement, he had practised this counter-irritation for years.

DR. TAYLOR presented a case of

MOLLUSCUM FIBROSUM OF THE BACK AND SHOULDER,

following a bite, and showed microscopic sections of the tumors he had removed. He stated that he intended reading a paper, at the next meeting of the Society, upon the development of these tumors, and requested that the discussion of the case be postponed till that time.

DR. ALLEN showed a case which all the gentlemen present regarded as one of

EPITHELIOMA OF THE FACE AND NOSE,

of the rodent ulcer variety. It had been regarded at a former time as a case of lupus, and it was conceded that it might have begun as a lupus and gone over into cancrioid or epithelioma, as sometimes happens. Under pyrogallic acid, the disease had greatly improved. The opinion of the members having been asked as to the best means of treating the lesions upon the eyelid, and near the inner canthus of the eye,

DR. MORROW said he had experimented extensively a few years ago with pyrogallic acid in lupus and rodent ulcer, but had never had the good results claimed by others. The use of mercurial ointment after the pyrogallic acid was regarded by Schwimmer as an essential part of his treatment. He believed that many lesions beginning as lupus became transformed into rodent ulcer or epithelioma. In the treatment of such affections, he preferred the chloride of zinc to all other caustics.

In a recent case of rodent ulcer, the extensive development of which precluded a radical operation, he had effectually kept the disease under control by occasional curetting, and the subsequent application of the chloride of zinc.

DR. SHERWELL had used pyrogallic acid and ung. hydrargyri, and had had good results. He says that in many cases the disease tends to cure itself, leaving a scar behind. He would suggest as treatment for the diseased tissue about the eye the application of nitrate of mercury, by boring into it with a sharp wooden stick or tooth-pick charged with the acid. If necessary, it could be neutralized afterward with soda.

DR. JACKSON suggested a strong resorcin ointment. He said a number of cases had done well in his hands under a fifty-per-cent resorcin ointment.

DR. ROBINSON would expect a decidedly better result from Marsden's paste; but about the eye would use a stronger caustic, such as the caustic potash or zinc.

DR. KEYES advised scraping, and the application of deliquescent chloride of zinc.

DR. FOX believed in the use of pyrogallic acid only after scraping. He had used Marsden's paste in lesions as near the eye as in this case. He regarded the chloride of zinc more painful, and no more beneficial.

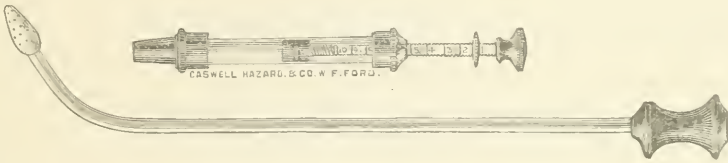
DR. TAYLOR presented a new

URETHRAL SYRINGE,

with the following description:

The syringe I now show is a modification of my original urethral syringe (see *American Journal of Syphilography and Dermatology*, October, 1870), together with certain useful and practical features of Ulltzmänn's syringe. It consists of a silver shaft with capillary bore, of short curve, of size of No. 6 French, at the end of which is attached an acorn-shaped silver bulb, perforated on its tapering sides by rows of minute holes. The apex of the bulb is rounded, so that in introduction the folds of urethral membrane are not wounded, while at its base it rounds off gently, but presents a shoulder as it merges into the shaft. The cali-

bre of the bulb is No. 20, French scale. By means of a rubber attachment piece, which serves also as a handle, the shaft is fitted to a hypodermic syringe, made of hard rubber. The advantage of this instrument is that a very minute quantity of fluid may be injected, and that the mucous membrane is sufficiently stretched by the bulb from which, being pierced by very minute holes, the fluid escapes slowly and evenly. With this instrument regurgitation of the fluid, even very slight, does not occur. A further advantage is, that the bulb enables you to re-explore any undulations, slight contractions or granulated spots, after previous localization of them, either with the bougie à boule or by means of the endoscope. In



my original instrument, there was a sliding button on the shaft which, after accurate measurement, could be slid to the proper place, and thus make sure that when introduced the bulb was at the morbid spot. In this syringe, the length is less than that of my old one, and yet it is not as short as that of Ulltzmans'. I have found, however, that the button can be dispensed with, and that with this syringe alone, if in a hurry, a diagnosis may be made, and the parts then covered with the injected fluid. This instrument, further, is capable of more extended and easy application than is the old Lallemand instrument. The passage of this instrument is not attended with nearly so much discomfort to a sensitive urethra as is caused by the blunt tube of the Ulltzmans syringe.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Lepra.

THE excellent work which Professor Leloir, of Lisle, has just brought out on leprosy is the most complete as well as the most recent monograph on the subject. I think, therefore, it should be brought to the attention of American dermatologists who have of late years paid so much attention to the question. The symptomatology of the two principal forms of this affection (the tubercular and the anæsthetic or trophoneurotic) is brought out in this work with the greatest care, utilizing writings which have already appeared on the subject, and giving ninety-one unpublished observations, of which many were made by the author himself. The chapter on pathological anatomy contains the latest researches known upon the morphology and the localization of the bacilli in the morbid tissues. As to the etiology, the learned professor, after having discussed the various hypotheses hitherto advanced, concludes with the opinion that leprosy is a

contagious disease. As regards treatment, he preserves a most prudent reserve, stating, with reason, that before a patient can be pronounced cured of lepra, he must be kept under observation, not months alone, but years. He does not think that stretching of the nerves should be practised in the pains of neuralgia, since it is about proven at the present time that the morbid conditions of the tropho-neurotic form of lepra depend wholly on lesions of the peripheric nerves, and in all cases this operation can only be palliative, and not curative. The leper should leave the region where the disease abounds, to take up his habitation in a non-leprous temperate clime; he should follow out a vigorous hygiene, eat plenty of healthy food, milk, fresh vegetables, eggs, meat, etc., observe the utmost cleanliness of his person, and, in addition, bathe the whole surface of the body with solutions of phenic acid or other disinfectant. His *morale* should be raised, and tonics should be prescribed, together with phenic acid, gurjun or chaulmoogra oil, or the medicaments praised by Unna; finally attempts may be made to destroy the tubercles by caustics or the red-hot iron. A superb atlas of twenty-two chromo-lithograph and heliograph plates is added to the text, completing this interesting publication.

Destruction of Hairs by Electricity.

During the past few months, I have been experimenting in Paris with the methods which the American dermatologists employ to destroy hairs growing upon regions where they should not exist. In June last, I communicated my first results to the Société Méd. des Hôp. de Paris. I operate with very fine platinum needles, soldered to little metal cylinders, which make it easy, held between the thumb and index, to move in any direction. So as to know the depth to which the needle has penetrated, I place, at five centimetres from the point, a mark with sealing wax. I have also had made some platinum needles with a metallic index at this point. The patient constantly holds in his hand a cylinder covered with chamois skin, attached to the positive pole. The needle attached to the opposite pole is introduced along the course of the hair down to its bulb, and the follicle is, so to speak, catheterized. An assistant now slowly turns on a current of from eight to ten milliampères, which I usually find sufficient. In operating in this way, the patient does not suffer from the painful shocks of the current, and the pain seems to be less severe. I pass over the thousand details of the operation, on which it is not necessary to dwell, since it is especially in America that this method has been studied. The results which I have obtained have been quite satisfactory. It is incontestable that in this way the hairs can be destroyed, and indeed without leaving cicatrices to any appreciable extent, especially if care is taken not to operate at any sitting upon hairs which are close together. The inconveniences of the method consist especially in the multiplicity of operations necessary, for we can scarcely destroy more than from thirty to fifty hairs at a sitting; in the intense pain which certain patients suffer, but which can, up to a certain point, be modified by interstitial injections of cocaine, and finally in the slight deformity which the inflammatory action causes, an inevitable result of the destruction of the bulb.

Destruction of Pigmentary Nævi.

In operating upon one of my patients for hypertrichosis, I caused a *nævus pilosus* which she had upon the cheek to entirely disappear. This procedure for

the destruction of *nævus pilosus* is already well known, and my personal observation only tends to confirm its usefulness. I have seen Dr. Besnier employ another means for removing a voluminous hypertrophic pigmentary *nævus* of the right side of the nose. He treated it with repeated cauterizations with the electric cautery, which he uses to destroy lupus tissue, and obtained excellent results. When I saw the case, the infiltration had greatly diminished, the nostril was much more pliable, and the pigmentation had almost entirely disappeared.

Treatment of Erythematous Congestion of the Hands and Chilblains.

This is the procedure of Besnier for combating the congestive state of the skin, so frequent in the extremities of young lymphatic subjects—a congestive state which causes a bluish aspect and a sort of hypertrophy of the hands and feet as soon as the cold weather comes, and predisposes to frost bite, which persists with the most discouraging tenacity. Dr. Besnier recommends for these patients foot and hand baths of a decoction of walnut leaves. Immediately after the bath, they are to use frictions with camphorated alcohol, and then powder the parts with the following mixture:

R Salicylate of bismuth..... 5 grams.
Amylum.... .45 “

They should avoid all exposure to excessive cold. At evening, if great itching is present, the friction with camphorated alcohol may be replaced by the following:

R Glycerin,
Rose Water.....āā 25 grams.
Tannin......05 centigr.

and the powder used as before. If the chilblains ulcerate, he advises that they be dressed with the walnut leaves which have been used to make the decoction.

Treatment of Erythema.

Bazin has described, under the name *erythème induré*, an affection of young women, of which Dr. Besnier has shown a fine example in one of his clinics. In this case, a girl of about 20 presented herself with plaques of an erythematous nature and a livid red color on both legs. Passing the hand over the lesions showed them to be distinctly elevated. In making pressure, the redness did not disappear entirely, but a yellowish tint remained, often accompanied by a small red hemorrhagic point. Decided pressure produced pain and transitory pitting.

The leg was increased in size, tense, and gave to the hand the sensation of fullness and resistance. This lesion, of which I have myself seen several examples, cannot be considered as an *erythema nodosum*, for it has not at all the color, consistence, limitation, and cyclic evolution. It usually persists for a long time, especially if the patient continues at her usual occupation and remains much on her feet. Dr. Besnier considers this affection as belonging to the lymphatic diathesis, and advises a general treatment; in particular, the employment of arsenic internally, rest in bed or in a horizontal position is necessary. It is well to aid resolution by the application of some astringent lotion, and moderate compression with a flannel bandage.

In the September number of the CUTANEOUS AND VENEREAL JOURNAL, page

285, will be found a communication of Dr. Villemin to the Acad. de Médecine upon "Polymorphous Erythema." During the months of July, August, September, and October, 1886, I had charge of the dermatological service of the St. Louis Hospital, and wishing to verify the observations of Dr. Villemin, I admitted to my wards a number of cases of polymorphous erythema. I first treated them expectantly, and saw several cases recover quite rapidly without any treatment whatever. This, however, is a common occurrence in the disease. If after three or four days a case did not improve, but remained stationary or increased, I gave the iodide of potassium in doses of two grams during the day.

In one case only, of papular erythema without general phenomena, was I enabled to see any good results produced, and almost always the eruption was aggravated by the administration of the drug. In one case in particular, where a young man of about 20 entered the hospital with a papular erythema of the lower extremities, complaining of a general malaise and lassitude, with vague rheumatic pains and light fever, I left him without treatment for several days, and then gave the iodide in the dose of two grams per diem, without seeing the phenomena decrease. The interne of the service now increased the dose to four grams daily, and the fever became almost at once intense, the erythematous papules increased, and many became vesicular and then bullous, and the patient appeared to be affected with a bullous polymorphous erythema of the most severe type, and the more so, as most of the bullæ rapidly filled with a hemorrhagic fluid. I stopped the iodide at once, and began giving large doses of quinine and ergotine, and soon the bullæ ceased to form, and the erythema itself disappeared entirely under the influence of these two drugs. I think, therefore, that I am in a position to say that the *controle* experiments which have been made at the St. Louis Hospital are favorable to the method of treatment advanced by Dr. Villemin.

Treatment of Warts.

Dr. Colrat has made a communication to the Soc. des Sciences Méd. de Lyon on the already known treatment of warts by the internal administration of magnesia. He has brought out several new facts, proving the real efficacy of this method. He has seen large warts with polypiform base disappear under the influence of the drug alone. It is true that among the children placed under treatment he has found some wholly refractory. Drs. Aubert and Roux have seen similar cases. In adults, from fifty centigrams to a gram a day is usually given. The action of the remedy remains unexplained, but we know that Cornil has discovered a special microbe in warts, and it is most probable that these productions are auto-inoculable. Nothing prevents making some local application at the same time that we give the magnesia internally. One of the most efficacious is salicylic acid in collodion, ten per cent. Dr. Vidal also occasionally applies potash-soap plasters.

Treatment of Blennorrhagia.

Dr. Lanné brought out, in the *Bulletin de Thérapeutique*, March 15, 1886, a paper on the use of kava in blennorrhagia and the acute affections of the urinary passages. From his researches, it appears that this remedy, for the knowledge of which we are indebted to Dr. Dupouy (*Journal de Gubler*, 1876), has the great advantage of modifying all the painful phenomena of acute period of blennor-

rhagia, at the same time that it changes the nature of the secretion. It fills, therefore, according to the author, an important place in the treatment of this affection. We know, in fact, that the balsams are only given without danger after a period of emollient, or better still, expectant treatment. On the other hand, kava can be administered from the very beginning, in the dose of six to eight capsules, each containing ten centigrams of the hydro-alcoholic extract. This dose, corresponding to one gram of the powdered kava, quickly eases the pain and modifies the discharge, the amelioration appearing with the onset of diuresis. Employed at a later period, it acts upon the discharge with as good results as other more usual internal remedies. The drug is well borne by the stomach and even seems to increase the appetite. It has not so far produced any artificial eruptions, and does not give any bad odor to the breath. The parts of the plant containing the greater part of the active principle are the bark and the root. The active principle is not yet well defined. Dr. Vidal has treated blennorrhagia for some time, and with much success by the internal use of the balsam of gurjun, giving it in the following combination. Balsam of gurjun and gum acaciæ, ãã 4 grams; syrup of poppies, 12 grams; infusion of anise seed, 40 grams. This draught is taken in two doses, before breakfast and before dinner. Dr. Vidal finds that this medicine has the advantage of not giving to the urine any odor, and of being administered without the patient's being forced to change his usual habits. It succeeds equally in chronic blennorrhagia, but may occasionally cause digestive disorders, and for my part, I have often seen patients forced to interrupt treatment. As with all balsams, its use must be continued at least eight days after the complete cessation of the discharge. Dr. Vidal treats vaginitis with equal success by the application of absorbent cotton tampons soaked in the balsam of gurjun.

Treatment of Simple Chancre.

Dr. Besnier has quite recently treated simple chancres in his service at the St. Louis Hospital by quite deep cauterizations with the fine point of the electro-cautery. He first canterizes the whole periphery with the greatest care so as to leave no point intact, and then operates upon the central part, and dresses with cold-water compress. He thus destroys all the virulent matter, and transforms the infecting sore into a simple wound. It is with the same view that Dr. Vidal advises applications of pyrogallic-acid ointment in five-per-cent strength until it has been completely cauterized and transformed into a simple wound, after which it is dressed like any simple ulcer. It is to the same end that Dr. Aubert, of Lyon, recommends topical applications raised to a temperature of 38° C., for, according to his researches, the virus or microbe of simple chancre is destroyed at this temperature. In an interesting lecture upon simple chancre which appeared in the *Semaine Médicale*, October 13, 1886, Dr. Mauriac advises the use of a saturated solution of chloride of zinc to cause destructive cauterization of the ulceration. Two or three applications are at times necessary, but often one alone suffices to bring about a radical change. The borders sink down, the base fills up, and healthy granulations appear. Nevertheless, the case must be carefully watched still, for the least particle of tissue which has escaped the caustic is sufficient to re-inoculate and bring back the chancre. Diday, of Lyon, employs for this purpose a paste composed of equal parts of chloride of zinc and wheat flour, which he applies over a shield of the exact dimensions of the chancre. For my

part, I have used iodoform as a dressing for chancroids, and have had excellent results; it has the very great advantage over iodoform of being inodorous, and consequently can be employed in private practice. I do not know what iodoform will do in cases of phagedenic chancre, and I think that when we find ourselves in presence of this complication, we should act with the greatest energy in employing either the chloride of zinc, pyrogallol, or the red-hot iron, and subsequently dressing with iodoform, iodoform, or salicylic acid.

Treatment of Syphilis.

In closing my letter, I will call attention to Dr. Mauriac's method of treating syphilis, which appeared in the *Semaine Médicale*, August 18, 1886. He does not believe it necessary to direct systematic medication against the syphilitic diathesis in the intervals of freedom from its manifestations; for the preventive action of the two drugs against syphilis par excellence, *i. e.*, mercury and the iodide of potassium, seems to be much inferior to their curative action. When manifestations show themselves, they should be attacked with one or the other of these drugs or by both at once, according to the nature and intensity of the lesions. In the interval, when the organism has returned to its normal state, the indication is to suspend treatment until a new course of specific medication is called for. According to the author, we must not be exclusive in the use of mercury and the iodide. Both have their indications and their usefulness. The iodide should be employed as often as there are present what were formerly called tertiary manifestations. Whether they be so considered from the form and features of the lesions or from the date at which they occur or time they have existed, Dr. Mauriac himself gives the iodide, even for the primary sore, whenever the induration is excessive or whenever it takes on an ulcerative or phagedenic appearance. On the other hand, it must not be believed that mercury should only be prescribed in the secondary period. There is at the present time a common notion that it should be used in the period called tertiary, in the treatment of nearly all the specific visceral lesions, either conjointly with the iodide or in alternating with it when large doses of both drugs are being used.

L. BROCCQ.

PARIS.

DERMATITIS FROM RHUS VERNIX.

Editor of the Journal of Cutaneous and Venereal Diseases.

DEAR SIR:—Having noticed letters in your JOURNAL concerning the poison of rhus toxicodendron and its cure, I wish to mention a similar disease common in the East, and its treatment.

Many foreigners, as well as natives, in the East are often troubled with what is termed "varnish poisoning." It is in some cases so distressing that the person cannot pass a furniture shop, where articles are being varnished, without being poisoned. With others it comes on after actual contact with furniture freshly decorated with the poisonous varnish. I have also noticed that comparatively old articles possess the poisonous property during the rainy season, when everything is covered with dampness.

As I am quite liable to the disease, a description of its effects upon myself may be in place. The first eruption occurred, while in Nanking, over my left eye, spreading to my forehead and nose. It itched and burned, causing great discom-

fort and disfiguring the face. Being ignorant of the effect of the Chinese varnish, I diagnosed the trouble as "herpes zoster frontalis," and treated it accordingly, but with poor results. Later I had a very severe attack in Shanghai, after receiving a new chair from a Chinese cabinet maker. The forehead became hot and itched intolerably; mind clouded, slight fever, and anorexia, followed by the appearance of minute vesicles on a raised base; swelling increased till the eyes were all but closed. It was diagnosed as "facial erysipelas," and I was urged to go to the general hospital. This being inexpedient, and there being a slight doubt as to the verity of the diagnosis, consultation was called and it was pronounced "varnish poisoning."

The treatment ordered was constant bathing in an infusion made from freshly cut camphor-wood shavings. These being less easy to obtain than the gum, aqua camphoræ was tried and found useless, after which instructions were followed out to the letter. In two hours from the first application, relief was obtained, and in twelve hours the trouble had disappeared. I have since often prescribed this treatment in foreign and native practice. It never fails; while the spirits and water of camphor, which are usually tried first, on the sly, always do fail.

This poisonous varnish is made from the rhus vernix or vernicia and is often mixed with iron rust, lime, and ox blood. It seems that it would at least be worth while to try this treatment for poisons of the rhus toxicodendron.

Sincerely yours,

H. N. ALLEN, M.D.

SEOUL, KOREA, Sept. 14, 1886.

UNGUENTUM BELLADONNÆ IN RHUS-POISONING.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

SIR:—I have been somewhat surprised at seeing so much in your JOURNAL relative to the treatment of rhus-poisoning, and yet nothing said of what I have long regarded the most important remedy in this troublesome disease; until, in the November number of the CUTANEOUS AND VENEREAL JOURNAL, Dr. T. J. Reid, of Chicago, mentions the proper remedy. I have long been in the habit of using belladonna in the treatment of rhus-poisoning, not the green vegetable bruised and mixed with fresh cream, as the doctor suggests, but in the form of the officinal belladonna ointment, locally applied. I have used this ointment in the treatment of many cases, and have never yet observed any bad results, but have uniformly seen the eruption disappear in from two to five days. I have never yet witnessed a return of the eruption treated with the belladonna ointment, without a fresh exposure to the poison. I have never used a solution of atropiæ sulphas which would perhaps act equally well as the ointment, and, no doubt, would be more cleanly.

I hope others will try this treatment, and report the result.

Respectfully,

JOHN H. BAILEY.

BORDLY, Ky., Nov. 17th, 1886.]

BELLADONNA IN THE TREATMENT OF RHUS-POISONING.

To the Editor of the Journal of Cutaneous and Venereal Diseases.

SIR:—I notice on page 345 an article by T. J. Reid, M.D., on the use of "nightshade" in the treatment of severe poisoning by "poison oak."

In 1850, I was poisoned badly by using some leaves of the poison oak after de-

fecation while in the woods, no paper being handy and not knowing the bad character of the plant. On account of wiping my face, which was perspiring, the itching spread over a considerable surface of my body, face, neck, etc., and in twenty-four hours erysipelas set in. My body, legs, head, and hands and arms were enormously swollen. At this time, a physician ordered a bath of salt-water, which only increased the intensity of fever, pain, and swelling. My grandmother came to see me, took charge of the case, and made an application of the following:

Jamestown Weed Leaves (stramonium),
Night-Shade Leaves (A. Belladonna),
Sweet Milk.

The leaves were boiled in the milk until soft, and the entire body was covered with the preparation, using only the leaves, and moistening them from time to time with the milk remaining.

For five days this treatment was continued, using twenty gallons milk and ten bushels of the mixed leaves. I lay on an enameled cloth sheet, and was covered with a sheet.

The leaves were kept on for twelve hours, when they were removed (usually dry from the heat of the body) and a fresh lot put on.

I made a good recovery and was out in twelve days from date of attack of erysipelas.

No unpleasant symptoms, from either of the poisonous plants used, appeared.

DR. BEN. H. BRODNAX.

BRODNAX, LA., Nov. 29th, 1886.

Reviews.

LA SYPHILIS HÉRÉDITAIRE TARDIVE. Leçons Professées par ALFRED FOURNIER, Professeur à la Faculté de Médecine de Paris, etc. Avec 31 figures par Alfred Forgeron. Pp. 650. Paris: G. Masson, 1886.

The more carefully and exhaustively syphilis is studied, the more numerous and complex appear the morbid manifestations it is capable of causing. Recent researches have tended to materially amplify our view of the pathological scene upon which the clinical pictures of this protean disease are projected.

The recognition of the intimate relationship of syphilis to tabes, rachitis, and many obscure diseases of the nervous system constitutes important additions to our knowledge of the vast complexus of its pathological relationships, the extent and variety of which we are only beginning to appreciate.

Probably the most important advances in this special branch of study within the past few years relate to the remote accidents of syphilis, especially its late hereditary manifestations. The attention of syphilographers has been particularly directed to the investigation of certain hereditary morbid states, impressed upon the organism by the syphilitic diathesis, which were formerly referred to scrofula or tuberculosis as the generating cause.

Fournier has been foremost and most active in tracing out these obscure

phases of hereditary syphilis, and he may be justly considered the pioneer in this comparatively unexplored field of syphilitic pathology.

In the work before us, the distinguished author has undertaken to demonstrate that not only does hereditary syphilis pursue its victims to a much more advanced period of life than is commonly supposed, but that many lesions and morbid conditions of misinterpreted origin, and generally attributed to scrofula, are in reality the late expressions of this inherited diathesis. His demonstrations rest upon an abundance of clinical observations in which a clear hereditary history and the results of anti-syphilitic treatment are absolutely conclusive.

By late hereditary syphilis is meant the "ensemble of syphilitic accidents which, derived from a hereditary infection, are developed at a more or less advanced age, during second infancy, adolescence, or in adult life."

The ordinary conception of hereditary syphilis has been that the force of the disease is exhausted during the first two or three years of infantile life, and that its influence is rarely manifest after the second dentition. In the last edition of Bumstead and Taylor, the assertion is made that hereditary manifestations are seldom seen after the twelfth, and never after the twentieth year. Fournier has, however, collected 212 observations of hereditary syphilis in which symptoms were observed 251 times between the ages of 3 and 28 years, and 21 times between 28 and 65 years. The greatest number of accidents occurred about the age of 12 years. After the 18th year, the number rapidly decreases.

The first part of the work is devoted to a consideration of the diagnostic elements of hereditary syphilis. Our Paris correspondent has already given the readers of this JOURNAL an enumeration of the exterior signs formulated by Fournier, upon which the diagnosis of hereditary syphilis is based, in an interesting resumé of his lectures delivered some two years ago at the *Hôpital St. Louis*.

In the second part of the work, the late manifestations of hereditary syphilis are elaborately treated. He includes in this group only those accidents in which a direct hereditary influence has been absolutely demonstrated, leaving aside many lesions which are presumably the offspring of this diathesis, but which are not supported by sufficient clinical evidence to justify their definite inclusion in this category.

A glance at the following table, in which the various lesions observed in his 212 cases of hereditary syphilis are grouped, will show their nature and relative frequency:

Ocular affections, 101; osseous affections, 82; cutaneous affections, 53; lesions of the throat, 46; cerebral symptoms, 42; troubles of hearing, 40; nasal lesions, 26; hepatic affections, 25; splenic lesions, 15; subcutaneous gummata, 14; renal affections, 12; lesions of the larynx, 10; affections of the cord, 8; testicular lesions, 6; pulmonary lesions, 5; arthropathies, 5; lesions of genital mucous surfaces, 4; lingual lesions, 4; lesions of the nerves, 4; diverse lesions, 15.

In the third and concluding part of this interesting work, a parallel is drawn between acquired infantile syphilis and late hereditary syphilis. Acquired syphilis in infants, he contends, is much less rare than is generally supposed. After establishing the propositions that syphilis is never communicated to the child from vulvo-vaginal lesions of the mother during accouchement, and that a child conceived by a syphilitic mother cannot contract syphilis from her after its birth, he discusses the numerous modes in which infection may be conveyed to children. Among them may be mentioned contamination by a syphilitic nurse, by

parents who have become syphilitic after its birth, by means of common objects, as the nursing bottle, tooth brush, sponges, spoons, toys, criminal attempts, vaccination, circumcision, and various accidental contagions.

Some of the salient points of difference in the general characters of hereditary and acquired syphilis in children may be briefly indicated.

Hereditary syphilis begins to manifest itself within a few weeks after birth, while acquired syphilis may appear much later, since the disease may not be contracted until after five, six, or ten years.

Hereditary syphilis makes its *début* by general or constitutional accidents, while the acquired form always begins with a chancre.

In hereditary syphilis, the child is small, stunted, with a pitiable aspect of senility; the skin is of a bistre tint, wrinkled, corrugated, and flabby; while in the acquired form, the facies is not altered, and the child becomes cachectic only in rare cases, and after the lapse of a certain time.

Certain symptoms are peculiar to hereditary syphilis, and are not at all, or only exceptionally, produced in the acquired form, such as frontal and parietal bosses, deformities of the nose, coryza, pemphigus of the extremities, pseudo-paralysis of the limbs from diaphyso-epiphysal dislocations, papular, papulo-crustaceous, papulo-excoriative eruptions in patches developed upon the face, and especially upon the chin and lips; these differ only by insensible shades from those produced by acquired syphilis.

He concludes, however, that the differential diagnosis of hereditary and acquired syphilis cannot, as a rule, be made solely from the examination of the patient; a rigorous investigation into the antecedents and family history constitutes the basis of the true diagnostic method.

In laying down this work, which embodies the *réultats* of much valuable and original research, we cannot too highly commend the method of the distinguished master. It is characterized by conscientious care and scientific accuracy, and may well serve as a model to other investigators. He subjects every point, every theory to the rigid test of clinical observation. His interpretation of obscure pathological phenomena is intelligent and unbiassed, and his conclusions rest upon a solid basis of clinical facts.

The literary excellencies which characterize all of the author's contributions to the literature of syphilis are admirably displayed in this work. His felicitous style, and his rare talent of exposition tend to invest even the dry analytical details, necessary to the elucidation of his subject, with interest.

THE MODERN TREATMENT OF ECZEMA. By H. G. PIFFARD, A.M., M.D., Clinical Professor of Dermatology, Consulting Surgeon to Charity Hospital, etc. George S. Davis, Detroit, Mich., 1866.

The author of this little volume is known as one of the most progressive representatives of dermatology in the country, and no one is better fitted for the task of presenting an exposition of the modern treatment of eczema.

After describing the chief clinical varieties of eczema, he devotes a brief chapter to a consideration of its etiology. As is well known, he occupies a middle ground between the German writers, who assign a subordinate importance to constitutional causes, and the French school, which recognizes eczema as the cutaneous expression of the herpetic or arthritic diathesis. His views upon

this subject, which were elaborated in his treatise on diseases of the skin published ten years ago, have since undergone no sensible modification.

In discussing the constitutional treatment of eczema, due consideration is given to the various hygienic, etiological, and diathetic conditions which affect the causation and continuance of this disease. In the direct internal treatment of eczema, three drugs are given special prominence, viz., arsenic, calx sulphurata, and viola tricolor. The author's views upon the superior value of the drugs have already been set forth in previous numbers of this JOURNAL.

In the local treatment of eczema, the various therapeutic agencies which experience has shown most useful are given, together with the best means of applying them. Among the novelties of modern local treatment is the peroxide of hydrogen, which the author highly recommends in the first and second stages, especially when the exudation is abundant and purulent, and the effect of which, he declares, is almost magical; reducing the purulent exudation, and permitting the formation of a new epithelium.

The use of fixed adhesive dressings, as the collodion and traumaticin combinations, is considered; the salve muslins of Unna are favorably regarded; the gelatin combinations are not, however, mentioned—an important omission, since medicated gelatin dressings are regarded by many dermatologists as an important addition to our local therapeutic resources.

The treatment of eczemas of particular localities is then considered in detail.

As a concise exposition of the most recent and approved methods employed in the treatment of eczema, this little book is eminently satisfactory, and we would cordially commend it to our readers.

Selections.

INTERNAL URETHROTOMY.

THE presentation of a paper by M. Le Dentu before the Société de Chirurgie de Paris, in which he proposed to resolve the question whether "urethrotomy, internal or external, is the sole method applicable in the treatment of strictures in which dilatation is impossible?" was the occasion of an animated discussion extending through several meetings. As an exposition of the views of many of the representative French surgeons upon this important subject, the discussion was notable and interesting. Dr. Delefosse has presented, in a recent number of the *Annales des Maladies des Organes Genito-Urinaires*, a critical review of the different phases of the operation and the opinions and results of practice of those who participated in this discussion.

He treats the subject under the following heads: 1st, instruments and mode of action of urethrotomy; 2d, results immediate and results of long duration; 3d, accidents; 4th, comparison of internal urethrotomy with other recognized methods of treatment.

INSTRUMENTS AND MODE OF ACTION OF URETHROTOMY.

"To-day," says M. Le Dentu, "with the exception of M. Horteloup who uses his own urethrotome, we all employ that of Maisonneuve, and perhaps all the

medium blade. To this M. Guyon likewise resorts in the numerous internal urethrotomies reported by his followers."

This opinion is true of French surgeons. The instrument of Civiale, modified by Caudmont, which gives to the operation a certain nicety and comparative precision, has been supplanted by the running blade of Maisonneuve, which cuts blindly.

While M. Horteloup regards this instrument, as modified, an excellent one, still he contends that its use is often attended with certain failures and accidents. In performing urethrotomy, one almost never knows the length or thickness of the stricture. When the cannulated sound is introduced, and the blade reaches the stricture, one never knows whether the contraction is two or three millimetres or two centimetres in length, and when, as often happens, it is excessively indurated, necessitating the use of considerable force, it is impossible, even for a practised hand, to suppress this force immediately upon passing the stricture, and the result is the blade may penetrate the membranous region and make an altogether useless incision.

As to the thickness of the stricture, the result is also dangerous: the conditions of a good urethrotomy are that the entire indurated tissue should be cut and no more. Now, with the running blade of Maisonneuve, it is impossible for the most careful surgeon to confine the incision within these limits.

The same objections to this instrument have been suggested by Thompson, Tillaux, and others. Dolbeau, in the famous discussion before this Society in 1865, thus formulated his objections: "The retrograde incision permits the division of the stricture, and nothing but the stricture, while, with that from before backwards, the surgeon is in the dark, he neither knows where he is or what he does. It is his instrument which conducts him, and alone makes the operation."

One may inquire why so defective an instrument is preferred by so many able surgeons. Guyon and Dubuc employ no other. Reliquet considers it excellent. Its simplicity and facility of manœuvre, however advantageous for an inexperienced operator, should not be considered by surgeons whose manual dexterity is above criticism. Other reasons, other causes have guided them.

According to M. Guyon, the object to be accomplished by internal urethrotomy is, not an incision which shall modify directly and instantaneously the strictured tissues, but the immediate establishment of a large opening which protects the patient from grave and menacing complications. Moreover, since the operation aims to augment the urethral calibre by a lozenge-shaped piece, it is better to take this piece in the upper part, which is the least involved, which is more uniform and more firm, and which is least capable of receding under the pressure of the instrument. In these cases the depth of the incision is not necessarily considerable, and the criticisms directed against the instrument employed are thus much weakened.

This leads us to consider the *mode of action* of urethrotomy. Upon this point M. Le Fort has enunciated the following astonishing opinion: "Formerly it was thought that the effect of internal urethrotomy was to cut the stricture into two valves; that these two valves, separated by the sound, remained separated, and that in their interval these formed a large cicatrix which restored to the canal its primitive size. Teevan, of London, compared the effect of urethrotomy to the action of a tailor who added a piece to a too narrow garment. *Nothing is more*

false than this conception. Just in the degree that cicatrization takes place, the two lips of the wound, separated by urethrotomy, approximate and leave in the canal only a linear cicatrix."

Opposed to this opinion are the results of Reybard's well-known experiments upon the urethræ of dogs, and the existence of perfectly organized extensible lozenge-shaped pieces in the urethræ of men who have been operated upon, as shown by autopsies. The large majority of surgeons at the present day accept the fact of this *artificial piece*.

The next question, is at what portion of the canal should this piece exist to give the best results? The pathological anatomy of stricture will throw light upon this point.

Strictures which form a complete annular ring around the urethra are rare, it is true, but it is also admitted at the present time that internal urethrotomy is of limited application. Our knowledge of the improved employment of bougies has reinvested temporary dilatation with its rights. With the exception of traumatic strictures and certain inflammatory organic strictures of a special nature, progressive temporary dilatation is the rational mode of treatment, and if autopsies cannot demonstrate it, reasoning establishes the fact that inflammatory strictures are tributary to internal urethrotomy only when they have become annular.

What, then, is the nature of this fibrous ring? According to MM. Brissaud and Segoud, the inferior part is composed of a fibrous segment; the lateral portions of segments of spongy tissue, absolutely respected; the superior portion of a segment of elastic tissue of new formation.

These anatomical considerations indicate that the section should be made in the sides of the canal and not in the upper part, notwithstanding its elasticity, contrary to the opinion of M. Guyon who strongly insists upon the superior section.

The cicatrix sought to be obtained is composed of two quite important elements, the cicatrix itself, which should be formed of a tissue as supple as possible, and the base of the cicatrix or cushion, which ought also to be elastic. The section being made in the lateral healthy tissues, the cicatrix will rest upon a cushion of normal spongy tissue with no fear of induration.

But it is necessary to consider strictures in which the pathological anatomy differs from that above indicated. When a stricture demands internal urethrotomy, it is generally annular, and the fibrous tissue forms a complete ring presenting a different thickness in the superior and inferior portions, due to the unequal quantity of spongy tissue which exists anatomically around the urethra in the region of the bulb. The problem is therefore this: A complete circle exists in the canal having the form of a finger ring, the part corresponding to the setting being situated in the floor of the urethra, is it better to cut the ring at the sides or through the middle of the setting? Is it better that the *piece designed to stop the gap* be placed in the inferior portion? This question has an important bearing upon the tendency to a recurrence, sooner or later, of the stricture.

The object sought for is that this cicatrix, this artificial piece, should remain supple and dilatable as long as possible, that its own tissue and its cushion should undergo as slowly as possible fibrous transformation. If the cicatrix repose upon a fibrous tissue, either because the stricture is not entirely divided or the section extends into the fibrous envelope of the bulb, this last will constitute the base of

the wound, and the recurrence of the stricture will be prompt. The superior section of an annular stricture will divide it only in part or easily reach the fibrous envelope; the inferior section, on account of the thickness of the bulb, possesses greater chances, after having entirely divided the stricture, of leaving intact a layer of spongy tissue; the inferior section seems, therefore, altogether the best.

To resume, then, as regards the choice of instruments and the mode of action of urethrotomy, the following conclusion would seem established by the discussion: the instrument generally employed is the running blade of Maisonneuve; the action of urethrotomy is effected by a piece supplied to the canal—the theory enunciated by Reybard.

RESULTS IMMEDIATE AND RESULTS OF LONG DURATION.

The benefits of an operation are to be estimated by the radical relief it affords, or, since internal urethrotomy cannot prevent a recurrence of the morbid condition, by extending this immunity to the utmost possible limits.

M. Guyon thus expresses himself: "I may, nevertheless, in order to be perfectly understood, plainly declare that internal urethrotomy, notwithstanding its great value, is only one of the agents of this delicate therapeusis, and that of all the methods used to restore the permeability of the urethra, there is only one which is applicable to every case. This method is dilatation."

M. Tolaillon considers internal urethrotomy as of rare application, as the *last weapon* against stricture rebellious to dilatation.

M. Trélat thus testifies: "Internal urethrotomy is not, I consider it well to be specific, a method of treatment of stricture of the urethra. It is an *adjuvant* to the treatment of stricture by progressive dilatation."

While these opinions are right in principle, the theory may be pushed too far. If internal urethrotomy is simply an operation having for its object the rapid establishment of the course of the urine, we should consider only the immediate results furnished by the different methods. From this point of view, the magnificent statistics of Holt in the employment of divulsion—703 cures in 714 cases—the excellent statistics of Syme from external urethrotomy, the method of Mayer, leave nothing to be desired so far as obtaining a free course for the urine is concerned.

But the question is quite otherwise for surgeons who, leaving aside immediate results, look beyond the simple opening of the narrowed canal and study the after-results.

From this standpoint, they should conscientiously study the best instrument to employ, the nature of the cicatrix, the section of the stricture, the place of the sound after the operation, and finally the subsequent dilatation.

The superiority of internal urethrotomy over divulsion is based upon the length of time which intervenes between the relapses and not, I repeat, upon the immediate results.

Two practical points were considered in the discussion: the application of the *sonde à demeure* immediately after the operation, and the time at which consecutive dilatation should be commenced.

M. Trélat ordinarily does not attempt dilatation of the canal until the eleventh day after urethrotomy. M. Polaillon introduces immediately after incision of the canal a suitably large sound of red caoutchouc, carefully washed in carbolated

water and smeared with pure vaseline. He leaves this sound in position twenty-four hours or longer, with the view of protecting the urethral wound from contact with the more or less septic urine. M. Sée does not pass the sound after the operation, believing that its presence would irritate the canal. M. Humbert never has used the sound and has had no accident. M. Sée no longer practises dilatation after the operation. M. Guyon does not introduce the sound until fifteen or sixteen days after the operation.

The general impression of the society of surgery is, that the *sonde à demeure* should be adopted rather than rejected. Moreover, reason and observation would favor the use of the sound; the pellicle covering the cicatrix not being well formed until forty-eight hours after the operation, the indication is to protect the wound as much as possible from contact with the urine while the wound is fresh—a wound open and carefully watched prevents infiltration between the sides of the canal and the catheter.

As regards subsequent dilatation, with few exceptions, the society admits its necessity. Opinions differ as to the proper time for beginning dilatation. I believe that *dilatation should not be commenced until every trace of inflammation has disappeared.*

ACCIDENTS CONSECUTIVE TO INTERNAL URETHROTOMY.

Those relating to hemorrhage and infiltration of urine have become so rare as not to have occupied the attention of the surgeons who joined in the discussion; the mortality after the operation was chiefly considered. M. Le Dentu reported the following statistics: In 25 internal urethrotomies, 2 deaths, 5 incomplete results, 18 satisfactory results. He draws the conclusion that internal urethrotomy is not so benign as one might imagine, when local lesions (stricture and cystitis) have begun to be reflected upon the renal apparatus. The fatal cases are not due to the nature of the operative intervention, they are attributable to the renal lesions, and in these cases we know that a simple catheterism may kill the patient.

M. Kirrmisson, on the contrary, reported the case of a patient with a tight stricture, complicated with cystitis and nephritis, in whom the operation was followed by the happiest results. M. Lucas Championnière was surprised to hear that urethrotomy was a bad operation. In all the cases in which he had practised it, the results were good, with no accidents. The large experience of M. Guyon had furnished extremely favorable statistics. From the 500 urethrotomies done by M. Caudmont and myself, the conclusions are equally favorable.

M. Trélat, responding to M. Verneuil, sums up the essential points in the debate as follows: "In discussing internal urethrotomy, we assume that we operate in ordinary conditions, and not upon individuals in whom an essential organ is profoundly attacked. In the clinic, we have to make a diagnosis of these anterior maladies, and we refrain from intervention when we recognize their existence. From this point of view, we do not charge the operation with a reverse for which it is not responsible."

It may be safely asserted that the operation of internal urethrotomy, with perfected instruments, with the subsequent treatment better understood and with antiseptic precautions, has undoubtedly advanced in favor with surgeons, and at the present day, this method has taken a definite and stable rank in the surgical arsenal.

COMPARISON BETWEEN INTERNAL URETHROTOMY AND OTHER METHODS OF TREATING STRICTURES.

MM. Le Fort and Despres declared that they had never performed internal urethrotomy. M. Ripoll, on the contrary, rejecting dilatation, employs only internal urethrotomy. Dr. Delefosse examines at some length the grounds upon which these two opinions, so diametrically opposed, are based. The chief objection to the radical practice of M. Ripoll is that a stricture treated by internal urethrotomy develops much more quickly than when treated by dilatation.

The majority of the members of the society maintain more moderate opinions; it adopts internal urethrotomy as a method of treating strictures where dilatation has not succeeded.

Another question was raised by the communication of M. Le Dentu:

Internal urethrotomy is a good operation, it may be; but does it give satisfaction in all cases in which it is practised? No; then instead of yielding unqualified adherence to this operation, we should consider whether other methods of treatment may not be preferable in certain determined cases.

The argument of M. Le Dentu in favor of divulsion did not carry conviction to the minds of the society. It is not possible to establish standards of comparisons from the standpoint of immediate results. Divulsion is a method of force, and consequently, should *à priori* inspire the greatest fears on the part of the surgeon, one never knew what is done; one passes an instrument and that is all, and when it is considered that this method has enjoyed a great popularity because of its immediate results, one is tempted to demand whether the especial merit of divulsion may not be to prove the tolerance of the urethra for methods the most audacious and the least appropriate to its physiological conditions.

CONCLUSIONS.

The conclusions which may be drawn from this long discussion on internal urethrotomy are, that the *Société de Chirurgie* is to-day much more in favor of this operation than when the famous discussion took place in 1865; that the subsequent accidents, so feared a few years ago, have diminished to such a point that the operation is regarded by the majority of surgeons as benign when the patient is in normal physiological condition; that progressive temporary dilatation is the best treatment applicable to strictures of the urethra; that when it does not succeed, internal, and sometimes external urethrotomy should be the chosen method; that no method completely prevents the recurrence of the stricture.

Dr. Delefosse gives the following previously published conclusions of his own:

1st. Internal urethrotomy should not be considered as a preliminary operation opening the way to dilatation, but, on the contrary, as an operation having its place in surgery, and of which consecutive dilatation should be only the corollary.

2d. Internal urethrotomy is not an operation committed to chance and to be made with all sorts of instruments. It requires as much precision, as much manual aptitude for the operation as the search and ligation of an artery, for example; consequently it is necessary to reject every instrument which does not furnish a degree of exactitude sufficient to divide the stricture and nothing but the stricture.

3d. These conditions of exactitude are better fulfilled by the *urethrotome à*

olive, cutting from behind forward, than with an instrument with a blade running from before backward.

4th. Urethrotomy will give by so much more a good result as the cicatrix and its cushion have less tendency to become fibrous. It has been said that it is necessary to consider the nature of the stricture rather than that of the cicatrix, the one engenders the other; the more advanced the stricture the less the chances of a good success and of finding spongy tissue at the base of the wound.

5th. Internal urethrotomy should be employed in the large majority of cases to the exclusion of all other methods, where dilatation, temporary or permanent, is not applicable.

THE THERAPY OF SYPHILIS.

WHOEVER has had much experience in the treatment of syphilis knows full well that the disease can and does sometimes get well of itself, and that this happy result is to be looked for the more the patient observes the universal rules of hygiene. At the same time we have no assurance that the recovery will be a permanent one, or that the disease will never again show itself by any symptoms, to say nothing of the possibilities of transmission.

It is important that these fundamental propositions should be brought prominently into the foreground in every discussion of the subject of syphilis therapy.

No clinical observer dares deny the fact that the inunction method of treatment is a powerful one, and one which in severe cases cannot well be replaced by any other. Were we to admit that mercurials in general, and inunctions in particular, are excellent in syphilis, not so much because of any radically curative properties as that they keep back and postpone the symptoms; and were it further to be proven that after the employment of this metal severe affections of the bones and other organs are more frequent than when the disease is left to recover spontaneously, nevertheless, in disturbances which are produced by syphilis in the central nervous system, the brain, etc, we must strive by active anti-syphilitics (in the first rank of which stands mercury) to bring about resorption of the disease products as quickly as possible. The sooner this is accomplished the less are long-continuing ulcerations to be expected, and the sooner is a *restitutio ad integrum* to be looked for.

Dr. Edward Lang (*Wiener Mediz. Wochens.*, Nos. 34 to 35), after this introduction to a paper on the treatment of syphilis, goes on to describe a new preparation for subcutaneous injection which he calls *oleum cinereum*. He prepares it from fat, oil, and metallic mercury, carefully mixed together and triturated until all the mercury has become disintegrated and a thick gray fluid is formed, in which, after a time, the mercury is found to be evenly suspended. Only after standing for days, the more solid parts of the fat and the metal sink so that in the upper layers there is a thin zone of oil. To avoid this it must be made in a cool place and stirred till it has hardened. Each cubic centimetre of the twenty per cent oil contains about twenty-three centigrams of metallic mercury. It may be melted by the heat of the hand when used. He injects usually in one place a tenth of a cubic centimetre, although in a few cases he has increased this dose to two or three tenths, and this is repeated once or twice in the week. If as much as two cubic centimetres is used, half is injected in one spot and half in another. According to the necessities of the case, this may be reduced to one injection every eight to fourteen days, or a larger quantity than that given above can be incorporated with the body in a short time, but in this event we must naturally

be on the lookout for mercurialism. The trunk, or better still, the back, should be chosen for the operation, avoiding with care the parts pressed upon by the suspenders. Persons with thin, flabby skins are not to be recommended for this method of treatment.

This gray oil has been found useful as well in local and regional treatment, the quantity being reduced as the lesion is approached. From a fiftieth to a hundredth of a cubic centimetre is sufficient for injection near a local manifestation of the disease. The small-sized Pravaz syringe is better for this purpose than the ordinary size used for general treatment. The beneficial influence of the preparation is best seen on the lymphatic glands whenever an injection is made in the region of lymphatic vessels. For enlargements of the glands of the joint and thigh which are so commonly encountered, the author chooses the inner surface of the middle of the thigh for his injection of from one one-hundredth to one-fiftieth of a cubic centimetre, and repeats, if necessary, in from eight to fourteen days.

He mentions a case of lymphadenitis behind the upper attachment of the sternocleido-mastoid associated with a chancre of the tonsil, which disappeared after one injection at the nape of the neck of a tenth of a cubic centimetre of the oil. Also periosteal gummata on the forehead are mentioned as having been apparently much benefited by injection of a small quantity of the mercury near their borders. Other gummy and ulcerative lesions appeared to heal more rapidly under these injections than they usually do when otherwise treated. Little satisfaction was given from the use of the oil in initial manifestations. Suppuration at the point of injection and inflammatory reaction about glans and prepuce commonly followed.

Attention is called to a calomel and peroxide of mercury gauze which the author uses in severe suppurating and ulcerating chancres, in moist papules of the prepuce and between the toes, in broken-down gummy tumors, ulcerations of the cervix and interior of nostrils, etc., etc. This gauze needs changing only so often as the suppuration makes it necessary, and is well suited for office and dispensary patients. In conclusion, the author states that he has no idea of offering these modes of treatment to supplant others, but that, under certain conditions, they might with advantage be made to act as substitutes.

THE PROPHYLAXIS OF VENEREAL DISEASES.

In an address delivered before a meeting of hygienists, in Barcelona, Dr. Louis Cortés took up the subject of the prevention of venereal diseases, briefly referring to the measures best suited to diminish the chances of contagion in impure congress (*Gazeta Médica Catalana*, Nos. 11 and 12, 1886). Quoting an old Spanish proverb which says that "the best thing in dice is not to throw them," the speaker urged upon his hearers the duty which lay upon them of warning young men of the danger which they incurred from sexual intercourse with prostitutes; they should be told concerning the consequences of such acts, and should be urged not to risk their health and even their life for the sake of a passing fancy. But, recognizing that such advice would seldom be listened to, Dr. Cortés proceeded to discuss the means which ought to be adopted for the prevention of disease. The essential of all such measures is cleanliness. The woman should wash herself carefully and should use the vaginal syringe thoroughly before each sexual act, and the mistress of the house should be compelled to provide facilities for such ablutions, and should be responsible for their proper performance on the

part of her pupils. Pure water, or that which has been rendered mildly antiseptic, may be used, and the injection should each time be continued until the returning fluid is absolutely limpid and clean. Venus should be adored only at the moment that she is rising from the water. As for the man, he should remember the Salernian aphorism: *Post coitum si mingas, apte servabis urethram*, and he should also take the precaution to direct a fine stream of water against the meatus immediately after the completion of the sexual act, in order to remove any impure matter which may have become lodged at the orifice of the urethra. The woman should also practise the ablutions above referred to immediately after sexual intercourse, in order to remove any materies contagii before it has had time to penetrate into the submucous tissues. Neither party should think of performing the act if there exist the slightest abrasion on any part of the genital organs, that is, of course, provided that the existence of such abrasion is known. The man should also examine his partner, as far as can be done without brutality, for evidences of syphilitic taint. One of the most evident and easily discoverable signs of such infection is the presence of enlarged cervical glands. These may be felt by passing the hand lightly along the sides of the neck and behind the ears, which may easily be done without exciting the woman's suspicions. If enlarged glands are felt in this region, there is no safety in anything but abstinence. A precaution which may be of service is to smear the glans with cold cream or vaseline. In conclusion, the author of the address recalled the precept of the celebrated Nicholas Massa: *Si vero quis cum infecta muliere coire voluerit, quod fatuum est, non moretur in coitu.*

THE IMMUNITY AGAINST SYPHILIS.

DR. ERNEST FINGER (*Centralbl. für Klin. Med.*, No. 37, 1886) says immunity can be acquired:

a. Through a previously contracted syphilis.

To diagnose a re-infection, it is not sufficient that, in a patient who has had syphilis, a new erosion appears with indurated base, for, as Fournier has pointed out, constitutional syphilis can be the cause of induration in subsequently acquired simple ulcer.

b. The birth of a child, syphilitic through its father, protects the mother, who has had no acquired syphilis from infection. This immunity is proven by the inoculation experiments of Caspary and Neumann. Finger has himself carried out this experimental proof in three cases, which he gives in extenso. Nevertheless, this immunity against syphilis of the mothers of hereditary syphilitic children is not absolute and positive in all cases. This is shown by the cases of Brizio, Colchi, and Ranke.

c. Hereditary syphilis which has run its course protects, according to current statement, against a new infection. In proof of this, the author cites some personal observations.

d. The children of syphilitic parents often appear, even when they seem healthy and present no symptoms of hereditary lues, to have, at least, an immunity for the disease (Diday and H. Lee).

e. Finally certain individuals appear to possess an immunity for syphilis for which we can give no reasonable explanation (Ricord, Fournier).

Many cases are known of in literature in which inoculation with the virus of syphilis has not been followed by any general manifestations, but has re-

sulted only in local sores. These cases are usually brought forward as demonstrations of the unicist's theory, but as the question of immunity does not enter into the discussion of such cases, the results in this direction are frequently lacking.

TREATMENT OF INFANTILE SYPHILIS (DIDAY).

IN severe cases, one should begin by prescribing two-thirds of a centigram of corrosive sublimate, or one centigram of the soluble mercury of Hahne-mann, in three doses in twenty-four hours. This should be increased by one-third of a centigram every three days, until a sensible effect is produced upon the mouth or upon the syphilitic symptoms. Then diminish the daily quantity, as in the case of adults, so as to maintain a slight action upon the gums. Once each day friction should be made with one or two grams of simple mercurial ointment (mercurial cerate) to begin with. A larger quantity, if necessary, may afterwards be used for each friction. If the skin is too sensitive, use frictions only every other day. Every second, third, or fourth day a bath additioned with two grams of the sublimate is to be employed. Later increase the quantity of sublimate gram by gram, until the bath contains four to six grams, according to the age of the patient. The duration of the bath should be about one-half hour.

Internally iodide of potassium may be given in a commencing dose of five centigrams and rapidly increased. In many cases it will be found advantageous to associate the iodide with mercury in the form of a mixed treatment. For example, the *liqueur de van Swieten* may be prescribed in teaspoonful doses in milk or sugared water.

In applying these precepts, due regard should be had to the age of the infants, their strength, their development, and the intensity of the disease to be combated.—*Gaz. Méd. de Nantes*.

INTERMITTENT TREATMENT OF SYPHILIS.

IN the *Centralblatt für Klin. Med.*, No. 41, 1886, Dr. Lewentaner, of Constantinople, refers to the fact that in the Wiesbaden Medical Congress the principal syphilologists, except Neisser, were enthusiastic in upholding the old method of treating syphilis; in other words, they approved of beginning the treatment only when eruptions are observed. He thinks that the social side of the question has been entirely lost sight of in the discussion. The danger is always present. The patient may prove an infecting agent to all with whom he comes in contact, and, again, few patients ever consult a physician upon the breaking out of secondary or tertiary symptoms, and, indeed, usually not until serious disturbances have begun to develop. It is this very delay which produces the tremendous number of cases of nose affections, perforations and destruction of the palate, syphilis of the brain, disease of the liver, etc. Chronic cases of rupia and ecthyma in adults which he has had occasion to treat, and which no medication in the world would overcome, are the results of this faulty method of treatment. On the other hand, the advantages of having a patient continually under observation, as well as being able to enlist his obedience in all matters of diet, hygiene, etc., because of the promise which may be held out to him of a permanent cure, are very apparent. The author gives two cases to prove the efficacy of Fournier's method, and adds the opinion that the data furnished by Fournier's own experience constitute a most effective argument in favor of the principles maintained by Neisser.

JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

VOL. V.

FEBRUARY, 1887.

No. 2.

Original Communications.

ON THE MODE OF DEVELOPMENT AND COURSE OF MOLLUSCUM
FIBROSUM, AND ON THE QUESTION OF ITS RELATION TO
ACROCHORDON AND OTHER CUTANEOUS OUTSHOOTS.¹

BY

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A STUDY of the history of molluscum fibrosum from the time of the publication of Ludwig and Tilesius' monograph (*Historia pathologica singularis cutis turpitudinis*, et cet. Leipzig, 1793) till to-day shows strikingly the great aid pathological anatomy has given to clinical study in the knowledge of this interesting affection. While to Bateman undoubtedly belongs much credit for quite clearly differentiating clinically molluscum contagiosum from molluscum fibrosum as distinct morbid processes, yet it must be conceded that to the investigations of Rokitsansky and of Virchow we owe our present knowledge which draws such sharp pathological lines between the two affections. In his admirable chapter on molluscum fibrosum, which is by far the best one in any language, Kaposi² says: "No practitioner has hitherto been able to observe the development and course of molluscum continuously during any lengthened period, for the simple reason that, owing to the incurability of the disease, the patients remain but a short time under the care of the same physician. Much, however, may be deter-

¹ Read before the New York Dermatological Society, December 21, 1886.

² "Lehrbuch der Hautkrankheiten." Hebra and Kaposi, Band II., page 242. Stuttgart, 1876.

mined with probability as to the development and course of molluscum from a comparison of the many nodules and tumors which are present at the same time in the same individual and which differ widely amongst themselves in size, shape, color, consistence, et cet.; whilst, on the other hand, their peculiarities show many signs of similarity and of transition. The anatomical conditions met with in molluscum afford essential help in this respect." It was my good fortune, about fifteen years ago, to have the opportunity of studying the development and course of this affection in the person of a young man for a long period of years, during which I made frequent painstaking observations, which were carefully written down from time to time. Further than this, I have had the opportunity of studying the affection in patients of my own and in those of some of my friends, and have thus here had the essential help which Kaposi has so clearly and tersely stated. I therefore feel that I am in the position to give a reasonably accurate account of this portion of the clinical history of molluscum fibrosum, which is to-day wanting. While Kaposi gives many of the features observed in the development, he does not, nor does he pretend to, give a consecutive history of the process of formation. Having, in the light of my chief case, aided by analogical evidence offered by others, traced the development and course of the molluscous tumors from their first appearance to their stage of permanence, we will then study them through, what exceptionally occurs, their period of involution or retrogression, when all the features are changed and when all that remains of them are certain warty outgrowths of the cutis to which the old term, used by Hippocrates for warty growths in general, *acrochordon*, may be applied. Having, then, established the direct relations between the tumor as the primary morbid process and the *acrochordon* as being essentially secondary to it, we shall be prepared to look back and see that, though Behrend and Simon were wrong in classing as allied to molluscum fibrosum such affections as degenerations of the sebaceous glands and ducts, sebum-warts, and *nævus lipomatodes*, they did not stray far from the truth in claiming at least an occasional relation between molluscum fibrosum and *acrochordon*, and certain forms of warts and moles known as *nævus mollusciformis*. Important as the first division of the subject is, the second also possesses both interest and importance, since for the last thirty or forty years very little, if anything, has been written on the interdependence of these various kinds of growths, and, with the exception of Wilson, no author even has attempted a classification of, or given a good description of the *acrochordon* and of its allied cutaneous outgrowths. While many authors are silent, others speak of *acrochordon* as pedunculated tumors and confound them with sebaceous glandular tumors and with sessile warts due to epidermal hypertrophy; while others again speak of it as a

benign growth similar in character to molluscum fibrosum, but containing also adipose tissue. This brief summary, which contains the essential facts, shows us that to-day we are really not clearer, if as clear, in our differentiation of the various interdepending forms of warty cutaneous outgrowths as was dermatology in the time of Plenck, 1783, or later in the times of Behrend, 1839, and of Simon, 1851. In fact, utter confusion reigns. The case which forms the basis of this paper presents the following history:

M. R., aged 23; Irish; a clerk; came under my observation in June, 1872. He was a healthy, rather intelligent man, who had had no other sickness during life than an attack of measles. He was very muscular, and had considerable adipose tissue. His father, mother, four brothers, and six sisters were healthy, and free from any skin disease. Over his body an eruption of tumors and certain warty, purse-like protuberances were to be seen. It was most copious upon the back, near the median line, from a point on a level with the umbilicus as far down as the gluteal region. Towards the sides and on the anterior aspect of the trunk it was less abundant. A few tumors were seated upon the scalp, the lower part of the neck, and as far down as the middle of the thighs. There was, in addition, upon the right lateral abdominal wall a fold of skin, which began at the right anterior superior spine of the ilium, and ran obliquely upwards and backwards, and merged almost imperceptibly into the integument within two inches of the spines of the eleventh and twelfth dorsal vertebræ. At its central and broadest portion, it was about three inches wide. The color was somewhat mottled, being in some spots normal, in others of a bluish tint. There seemed to be a thinning of the epidermis. If this flap of skin was pressed between the thumb and fingers, the same sensation was conveyed as is found in an old varicocele. Quite well-developed, thick strands of fibrous tissue seemed to be mixed up together, which might readily be taken for swollen veins. This tumor was, like the rest on his body, painless unless subjected to undue pressure. The affection of the skin observed in this case, fibroma molluscum, was divided into two varieties of tumors, one made up of swellings or pouchings out of the skin, varying in size from two lines in area to those of a diameter of five-eighths of an inch; some were larger and being both round and oval. The second variety was composed of very many warty growths, or nipple-like pouches of the skin, some of a slightly pinkish, others of a slightly brownish color, which seemed to be a protrusion of the epidermal or more superficial layers of the skin. The tumors of the first variety were much less numerous than the warty growths, they being in the proportion of about twenty-five or thirty to one. These two varieties of elevations of the skin were scattered over the parts already mentioned in a most irregular manner, the solid eleva-

tions being in greater number in some spots, and the warty growths in others.

When the tumors of the first variety were carefully studied, it was evident that certain striking differences in appearance observed were due to changes in their development; consequently, it is necessary to study this first form, which represents the fibroma molluscum in all of its phases, in each stage of development, and of its retrogression in the clinical features presented by the warty growths.

The first stage in the development of fibroma molluscum is seen to be a slight uplifting of the skin in the form of a somewhat round spot, having an area of a quarter of an inch and even less, being slightly convex, and at its highest part being frequently at this stage about one-half a line higher than the normal plane of the skin. These young spots or elevations are at first of a very light pink, later many are of a rosy hue, even of a reddish and slightly bluish color. This increase of color is not absolutely limited to the surface of the morbid growths. Examined thus early in their development with the tip of the finger, the molluscous tumor feels soft, and much more readily depressed than the rest of the skin, and conveys the idea that the whole derma is slightly thinned. As the tumors grow larger, and when they have attained a diameter of about half an inch, they can be studied with much more accuracy. Thus, if the tip of the index finger is placed directly upon one of these spots at this time, or at any time until it undergoes retrogression, if that occurs, it can be pressed gradually and slowly downwards into the skin, and a sensation is conveyed as if the integument is pierced by a hole. Undoubtedly there is a round or oval spot of thinned derma in which the uplifted tissues can be invaginated; this thinning of the derma proper can be readily appreciated from the time of the earliest appearance of the tumors as slight, soft swellings up to their reaching the size of a nutmeg, and perhaps later, not only by pinching it between thumb and forefinger, or by grasping a fold between the blades of a forceps horizontally held, and also by pressing very gently, but firmly, with the end of a probe or other small instrument, and then suddenly withdrawing the pressure. Thus treated, the skin over the morbid growth is easily indented, and slowly rights itself, whereas on the healthy skin the rebound is prompt and sharp. Up to the time of the maturity of the molluscous tumor, it is evident that there is structural continuity between the underlying morbid growth and the skin above. This fusion of the newly-formed elements with the skin takes place quite early in the development of the molluscous tumor. In some instances I found very small subcutaneous tumors by careful palpation and examination, which later on contracted adhesions with the skin, and later became salient.

Reviewing, now, the development of fibroma molluscum, we find that it begins subcutaneously; whether, as Rokitansky thinks, in the deep connective-tissue meshes, or, according to Fagge and Howse, in the connective-tissue wall of the hair-follicle, or further, according to Virchow, Kaposi, and many others, from the connective-tissue framework of the fatty tissue, I am unable to say. Beginning as a minute circumscribed neoplasm, it pushes upwards and contracts adhesions with the overlying skin, then, increasing in volume and area, it shows itself as distinct tumors, at first, and in some cases in all stages, covered with skin of normal hue, or at first of slightly-pinkish color, which may increase to a red, and even to a red and blue or mottled color, according to the condition of pressure upon the vessels and capillaries in the overlying skin. With this explanation, I think nothing further is required in describing the color of the tumors of fibroma molluscum.

When the tumors have reached a diameter of nearly one inch, their course can be studied quite accurately. At this time the tumor will be either round or oval, according to the direction of the bundles of the strong subcutaneous connective-tissue framework of the part invaded. On the back they are mostly round, while on the sides of the body they are oval, and their axes show a tendency to follow the oblique line of the ribs. Whether round or oval, in general it may be said that a tumor reaches its full development when it occupies an area of an inch, though they may grow much larger. Thus formed, it may remain for a long time indolent and unchanged, or it may slowly increase and become hard and firm, and whereas it was at first to the feel rather soft and slightly compressible, it becomes hard and unyielding as it slowly increases in height and area. Or from the period of full development, it may gradually retrogress, and later be replaced by the warty growths, pouches, or nipples to be considered later on. My studies of my own cases, and my reading of those of other observers, teach me that, in general, retrogression of the tumors of fibroma molluscum occurs mostly, and perhaps I may say only, in young subjects, particularly in those under twenty years, and that beyond thirty it is very exceptional to see involution. I have never seen it at this age.

When the tumor reaches a goodly size, certain changes may be observed in its shape. Thus it may become broader at its base, and result in a sessile tumor, in which event it is usually permanent; or, again, the protruded portion of the tumor may increase in volume in a greater degree than at its base. The result is that we find, later on, a pedunculated tumor which, continuing to grow, may become pendulous, and constitutes then what the older writers called *molluscum pendulum*. Further, a tumor may grow large of itself, and even may fuse with other tumors, then the activity of growth in the elevated portion of the neo-

plasm continues with rapidity and great increase, and a true flap of skin is formed, called sometimes dermatolysis. The case I have recorded showed well this condition, and it has been frequently observed even in greater size in other cases. The cases of dermatolysis in which there are no co-existent fibroma molluscum tumors have undoubtedly begun and developed in the manner just described. One of the most notable examples in literature is the case of Marcacci,¹ in which the tumors sprang from the occiput and base of the neck, and developed into mammoth proportions, covering large parts of the anterior and posterior surfaces of the trunk.

Let us now go back again to the study of the course of the fibroma molluscum in the young patient whose history I have given. When the tumors had reached an area of not quite half an inch, their elevation was hardly sufficient to allow of their manipulation, except that they could be invaginated by a small finger. When larger, they were readily examined, and between the thumb and forefinger uniformly a sensation was conveyed as if there was contained within a number of thread worms or of boiled vermicelli. In such tumors, the neoplasm is soft and gelatinous, and may be attended with exuberant growth, since they may either increase rapidly or begin to wither and undergo involution. This condition is in marked contrast with the feeling and consistence of the tumors of slow growth seen in older persons, in which we find a perhaps lobulated, and perhaps solid tumor, but usually hard, firm, and resistant to pressure. In the case under consideration, almost all of the tumors were of this soft consistency, while in other cases of older subjects, I have observed scarcely any tumors but those of fibroid structure. I am led to believe, therefore, that the softer and more exuberant tumors are seen in earlier life, whereas the harder and more dense ones are developed later in life. Certain it is that the older the patient grows the more slowly do the tumors grow, and that with the slowness, there is greater density of structure. As a corollary of this, it may be stated that, in proportion as the tumor is of rapid development and of succulent structure, so is its tendency to involution greater, and that in proportion as the growth is slow and condensed, so is the future of the tumor that of permanence. When removed, the soft tumors are found to be of a gelatinous structure, and to adhere to the fingers, while the older ones are firm and resistant. Under the microscope, the former are found to be composed of a succulent, œdematous, wavy connective tissue with many cells, while in the latter the fibres are firm and not œdematous, and the cells less numerous.

Let us now study the features observed in the process of retrogression

¹ "Di un Raro Esempio di Fibroma Mollusco." *Giornale Italiano delle Mal. Ven. e delle Pelle.* Vol. xiv., 1879, page 193.

or involution of the molluscous tumors. The soft contents of the tumors are distinctly adherent to the cutis above them in the period of full development, and the atrophy of the skin which may occur is found to be in exact proportion to the rapidity of development and to the firmness of the structure of the tumor. In the soft form, the skin may be, or at least often seems, perfectly normal in thickness, while over old and firm tumors it is generally more or less thinned and adherent to the neoplasm. In young persons, therefore, there is very little destruction of the skin up to the period of full development of the tumor; later on, it may occur in the manner yet to be described.

Being fully matured, the tumor, which undergoes retrogression, gradually grows more pedunculated. It seems that, then, the skin around it begins to grow narrow, and that the mouth of the pouch of skin, if we may thus term it, grows smaller, just as by the strings of a purse we may close it more or less. Indeed, this gradual encroachment of the surrounding skin upon the base of the pouch-like tumor plays an important, perhaps the most important, part in its retrogression. Coincidentally with this circumferential closing up of the skin, the invagination of the tumors grows less and less easy of accomplishment. Evidences of involution are now seen in the tumors themselves. The adherence of the neoplasm to the derma at the period of development being well marked, it may be found to become detached gradually so that the overlying skin can be readily pinched over the tumor. To be more minute, at first the skin proper can only be pressed together by forceps held horizontally to the plane of the skin, and very soon a fold can be grasped between the thumb and forefinger. Then, as the neoplasm slowly retrogresses, it can be felt to gradually melt away or withdraw in salience and breadth, and then continue until in some tumors only a fibrous cord can be felt contained in a flabby pouch of skin. Traction on this showed that the cord was deeply attached to the connective tissue underneath. In proportion as the neoplasm melts away, so does its cutaneous envelope and the encircling ring of skin at the base of the tumor undergo change. The skin itself becomes flaccid, and then gradually wrinkled. The color pales visibly, since the tension of the capillaries of the skin is much lessened. The circumferential closing of the skin around the base of the tumor goes on gradually and slowly, while coincidentally the skin becomes thinned and more wrinkled, and the tumor less salient, more circumscribed in area, and difficult to grasp. This we may term an intermediary stage in the life of the molluscum; it is no longer a tumor proper, nor has it yet become a warty growth. In the case which forms the main basis of this description, the area of the tumors was about one inch before the retrograde changes took place, yet I saw the process overtake larger and even smaller tumors. The further

features of involution are similar and continuous to those already described. The circumferential constriction at the base of the tumors steadily goes on, and there is often an appreciable thickening of the skin at this point. The hole in the derma gradually closes up, and in time no evidence of the neoplasm can be seen or felt. What has become of it we cannot say. It is probable that the young connective tissue forming the growth has undergone fatty degeneration, and has been absorbed. It is an interesting question yet to be solved, whether the ring-like constriction of the skin at the base of the tumor has any influence on its degeneration. Whether, in proportion to the growth of the ring-shaped constriction, there is a concomitant pressure on the vessels which tends slowly to strangulate the growth of the contained neoplasm, we are unable to state.

While the above-described changes have been going on in the neoplasm and in the circumambient zone of skin, the cutaneous envelope of the tumor, which has become a mere empty pouch of skin, grows slowly and gradually less in height and area. In the case under consideration, these warty growths or purse-like outgrowths of skin were of various sizes, from that of half an inch in length and from two lines downwards in area, in every degree until they were found to be the size of a canary seed, and even as small as a bird shot. The larger ones could be extended from the skin fully half an inch, as a thin, wrinkled pouch, translucent and firmly continuous with the plane of the skin. This long outgrowth, when traction ceased, gradually subsided, coiled itself up, and presented the appearance of a pedunculated mole or warty growth.

Very many remained thus large, forming tumors of the size of a pea, while the greater number underwent slow retrogression, until they finally became a little warty growth which could scarcely be pinched between the nails. Thus we see that what had been a well-marked tumor of fibroma molluscum had successively become an undoubted cutaneous pouch, which had gradually withered until it had formed either a pea-sized pedunculated tumor or even a very minute warty growth. Years ago I snipped off a growth of this kind of the length of half an inch, and submitted it to microscopic examination, and found no evidences of true skin whatever. It was composed of simply a tissue of fibrous structure covered with epithelium.

On the space of four square inches I counted eighty of the minute warty growths of various sizes. Seen in a group, they look like so many minute nipples, being in color very much like the virgin nipple or the scrotum of the young boy. In some a faint brown color could be seen, but none of them possessed the hue of normal skin. To the touch they presented a peculiar soft, velvety sensation. The most minute ones thus remain and never undergo further retrogression.

In the early part of the stage of what I may call warty formation, the distended skin may be invaginated by means of a probe, and this procedure may be practised generally in the larger and permanent growths. But as the outgrowth grows smaller, invagination by any instrument becomes more difficult, and is finally found to be impossible.

The time occupied in the development of the tumors varied. I traced the course of several tumors until they attained a diameter of half an inch, which occupied a period of four months, and again I saw several of the same size fully eight months in reaching their growth, while in other and larger ones fully a year elapsed before maturity. As the patient grows older the time of development and decline become more prolonged. The period of involution and retrogression also varied in length. I saw several tumors which grew to a diameter of half an inch which occupied eight months in the period of involution. But the patient assured me that his relatives and he himself had seen fully two large crops of tumors come and go and leave the warty outgrowths in the period of one year. He thus had had successive crops from his earliest days.

Though the vast majority of the tumors had a self-limited existence, very many come to stay, as the facts of his history show. The large dermatolytic flap was, of course, permanent. As the patient grew older, the tumors were much less numerous, grew more slowly, and were permanent.

I think I need add nothing further as to the mode of development of the fibroma molluscum tumors. The facts observed speak for themselves fully, and I think bring out the clinical history very clearly.

The teachings of this case, however, are still further of very great importance as showing the undoubted relation between the fully formed tumors and the warty growths. In my description thus far, I have contented myself with calling these little outshoots of the skin warty growths, and have not applied to them the terms *acrochordon*, *weiche warzen*, *venues charnues*, *moles*, *ecphyoma mollusciforme* (Wilson), and *cellular tissue polypi* (Förster), for the reason that I did not want early in the essay to introduce a polemical element. With the facts already brought out, I think I am in the position to claim that in this case certainly there is the closest possible relation between the fibroma molluscum tumors and the warty growths, call we them either names, *acrochordon*, *ecphyoma mollusciforme*, or any of the others.

My studies of this case and of very many others, presenting the lesions known by the laity as moles, mothers'-marks, berries, warts, and by the profession as *acrochordon*,¹ *ecphyoma mollusciforme*, in Germany

¹ Hippocrates (B. C. 450), in his aphorisms, described *acrochordon* as an integumentary wart, growing like the end of a thread from the skin and being found in

as weiche warzen (Simon), and cellular tissue polypi (Förster), in France as venues charnues, and among English-speaking physicians sometimes as soft warts, have led me clearly to the conclusion that their mode of development is in all essentials similar to that just traced in the lesions of this case. Perhaps in utero or after birth, at a longer or shorter interval, a protrusion of the soft, rapidly-growing derma occurs, perhaps caused by a subcutaneous neoplasm, fibrous or adipose, or perhaps as a simple sacculatation of the skin. In either case the same phenomena occur. The growth becomes pedunculated, the contents more or less absorbed, and finally the little blemish or blemishes—as there may be several—of the skin are formed, and there they remain, the date of their origin and their nature alike being a puzzle to the lay and medical mind. In some cases, we find that absorption goes on until a long thin protrusion of atrophied skin, which is simply a layer of fibrous tissue covered with epidermis, remains, and when unextended it sinks down and coils up on the surface in the form of a small pedunculated warty

children between the age of dentition and manhood. (E. Wilson, "The Dermal Pathology of Hippocrates." *Journal of Cutaneous Medicine*, Vol. 2, page 17, London, 1868.)

Celsus (B. C. 18), speaking of tumors resembling warts, says 'one kind the Greeks call acrochordon, wherein is a development of something hard and uneven under the skin, the latter retaining its natural color. (E. Wilson, "The Dermal Pathology of Celsus." Appendix to *Journal of Cutaneous Medicine*, Vol. 2, pages 12 and 13.)

Paulus Aegineta, seven hundred years later than Celsus, says, "The akrochordon is a small rising of the surface, free of pain, callous, for the most part round and heavy, a narrow base so as to appear to hang. It is so called from its resemblance to the end of a cord. (E. Wilson, "On the Dermal Pathology of Paulus Aegineta." *Journal of Cutaneous Medicine*, Vol. 3, page 33. London, 1867.)

The ninth class of Plenck's classification includes *excrecentie cutaneæ*, and under this head includes warts, of which he makes nine varieties, the second of which are pendulous warts (hängende warze, stengelwarze), which include acrochordon, which he says hang from the skin by means of a little stem. ("Lehre von den Hautkrankheiten," Wien, 1777.)

Wilson, in his chapter on developmental and nutritive affections ("Diseases of the Skin," 7th edition, Philadelphia, 1868, pages 328 and 329), following Mason Good, considers these pendulous growths of the skin under the term ephyma and allied to warts. He makes two varieties, ephyma mollusciforme and ephyma acrochordon.

The first variety is a prominence of the skin produced by simple growths of the integument, more or less pedunculated, sometimes sessile, of sizes between a pea and a walnut. This also is called *nævus mollusciforme*. The second variety, or acrochordon, or, as he terms it, pedunculate wart, is a diminutive form of the preceding.

The venerable age and expressiveness of the term acrochordon should, I think, commend it to us for retention in our nosology. To Sir E. Wilson certainly belongs the credit of having kept its memory green.

tumor of velvety feel. In the majority of these tumors there is no possibility of invagination, so compact has the circumferential contraction of the skin become. Yet occasionally we find a tumor which, when drawn from the body, becomes trumpet or funnel shaped, from the fact that at its central portion there is a hole in the skin into which a fine probe may be pushed, carrying the protrusion well under the derma, in fact, completely invaginating it. I think that this fact, which I have several times observed, clearly proves the origin of these growths to originate, as I have said, in protrusions of the skin. This is the *acrochordon*.

Allied to this thin form of growth we sometimes find firm fleshy growths distinctly pedunculated, in many of which invagination may be practised by means of a probe. These only differ from the thin form in structure, and not in the mode of development. The protrusion of the skin occurs, the contraction at the base begins, and a pedunculated tumor is formed, but absorption does not occur, and we find the tumor made up of nearly normal derma, with perhaps some increase in the fibrous tissue. These tumors are always larger than those of the first form, have a well-marked firm consistence, are pedunculated, less thrown into folds than the more warty tumors, and often umbilicated. They are met with, owing to vascular conditions, of various colors, either that of the normal skin, or red or even purple. They are called by the laity berries, and regarded as birth-marks, caused by some impression on the mother of the bearer, by having seen berries, be they strawberries, blackberries, or raspberries, according to the permanent or transient colors they have or may possess. Again, some of them are the seat of deep-brown pigmentation or, again, of hairy growth, and thus receive different names from the people: black moles, hairy moles or warts, etc. Pedunculated generally, they sometimes are sessile, particularly about the face, and sometimes they may be invaginated. These tumors are known in medicine as *nævus mollusciformis*, *cephyma mollusciforme*, and *nævus spilus*.

These observations, therefore, bear out the statement of Simon and Behrend, who considered *molluscum fibrosum* as allied to *nævus mollusciformis* and *acrochordon*, since I have seen the former develop into the latter. In the light of this communication, those who may be interested may with profit read Simon ("Die Hautkrankheiten," Berlin, 1851, pages 231 *et seq.*), and study with care the figures in his fifth plate; he may also consult Behrend's Atlas and his description of the eighth class of skin diseases, which he calls hypertrophies of the cutis ("Ikographische Darstellung der Hautkrankheiten," Leipzig, 1839, pages 62 to 64, and plates xix. and xxviii.).

ON DILATATION OF URETHRAL STRICTURES, OF LARGE CALIBRE,
IN THE TREATMENT OF GLEET.

BY

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NOTHING is more distinctly laid down in the writings of authorities in regard to the treatment of urethral stricture than that the results of dilatation are always of a temporary character. It is therefore well understood in the cases of cure of gleet by dilatation of the stricture or strictures upon which it is dependent, that subsequent dilatation must be kept up, *indefinitely*, at varying intervals, in order that the gleet may not be re-established.

For a permanent cure, a complete division of the stricture or strictures must be had, and any treatment which falls short of this will, of necessity, fail in doing more than to temporarily remove the obstruction which has been the cause of the gleet. It is, however, desirable that a temporizing course should be pursued in many cases, for various reasons, just as in many cases it may be found better to pay the interest on a mortgage rather than to pay it off. In some cases, there will be want of time and means; in some, lack of the instruments, skill, and experience necessary to a radical cure of the stricture. In a very large proportion of cases, the prejudice against any cutting operation will be the sole objection, and this is encouraged by the advocates of dilatation who refuse to accept the well-authenticated evidences of prompt, satisfactory, and complete cure of stricture and of the gleet through complete division, and who persistently ignore the possible perils of its continuance. These also underrate the dangers of dilatation, while exaggerating the risks and discomforts of dilating urethrotomy. For such and perhaps other reasons, the treatment by gradual dilatation will be required in many cases. Directions for its proper performance are therefore appended, as follows:

For dilatation of strictures of large calibre, or those above 20 F., I prefer the solid nickel-plated sound. The essentials of a solid metal instrument, for easy passage through the urethra, are; 1st, that it shall have a highly-polished surface, steel or nickel-plated; 2d, that its extremity shall be so curved that, in its passage through the urethra, it shall naturally follow the course of that canal, readily conforming to what is known as the *sub-pubic curve*. Urethral sounds, as usually constructed, consist of a straight portion, from six to eight inches in

length; the curved portion from two and one-half to three and one-quarter inches in length on its convex surface. The length of this curve between these limits is not of importance; the one, as a rule, which is the easiest of introduction is that to which you are most accustomed. Sir H. Thompson and Prof. Van Buren's sounds have a curve of three and one-fourth inches. My own preference is for the shorter curve; this seems to me more easy to direct, enables the operator to be more sure of the exact locality of its point than those of the longer arc, and readily adapts itself to the sub-pubic curve.

The sub-pubic curve is found in the well-formed human subject to correspond to the arc of a circle three and one-fourth inches in diameter, the chord of the arc being two inches and three-fourths, and coincides with the course of the urethra from its junction with the bladder to a point an inch and a half anterior to the bulb. The lowest point of the curve is just about opposite the anterior layer of the triangular ligament when the body is upright. In children this curve is more acute, and in old men with enlarged prostate it is more obtuse (Sir H. T.), but in the well-formed adult it is as above stated.

All solid instruments intended for passage through the deep urethra should be formed so as to correspond to the *sub-pubic curve*, and this curve should always be borne in mind when attempting to introduce such instruments.

Mode of Introduction.—Taking up the penis carefully, so as partially to include the glans between the first two fingers and thumb, and taking up the sound lightly as you would a penholder, introduce it well oiled, pretty much by its own weight, turning it slowly if any halting occurs, in this way releasing its point from any obstructive folds of mucous membrane or engagement in a false passage, or natural sulcus. The larger the instrument used the less liable to arrest from such causes. Always begin with the largest instrument which the meatus will permit. In cases of contracted orifice, a division may be necessary before any satisfactory introduction can be effected.

As the sound is advanced, gently draw up the penis on the sound to meet it, keeping handle of the instrument well down as the abdomen is approached, thus avoiding arrest by the anterior border of the triangular ligament; then advance by slowly depressing the handle until the instrument, following the deep urethral curve, passes well into the bladder. Obstructions may, however, be met. In the anterior or movable portion of the canal, if there be no stricture, we need have no trouble in passing a large instrument. Small instruments, however (say of eight or ten m. circ.), may engage in the little follicular sulci which are not infrequently present at different points, especially in the superior wall of the urethra. Quite a large one is usually met at about one inch from the urethral ori-

fice. This is called the *lacuna magna*. Spasmodic contraction of the anterior urethra is rare, but if the mucous membrane is in an irritable condition, it may arrest, temporarily, the progress of even a full-sized instrument. It is at the bulbo-membranous junction, from five to six inches down, that we are most likely to have an instrument arrested. First mechanically, by the anterior border of the triangular ligament. A little tilting upwards of the handle of the instrument will clear this obstruction, and then the point will bear against the anterior aspect of the membranous portion of the urethra. The circular muscular fibres which surround this are continuous with the muscular coat of the bladder, and are abundantly developed here; besides these, the compressor urethræ muscle surrounds the whole length of the membranous urethra. It is here that the spasmodic contraction of the muscular structures surrounding the canal most commonly hinders, to a greater or less degree, the advance of instruments, not seldom completely barring their passage into the bladder. Arrest of an instrument at this point *is the rule*, and undue haste or violence will but increase the difficulty. The simple weight of the instrument, allowed to bear steadily against the face of the closed walls for a few seconds, will usually cause the contraction to yield; when, slowly depressing the handle of sound, it will glide easily into the bladder. The interval between the act of introducing sound or other instrument for the gradual dilatation of stricture should never be less than two days, and, where irritation is produced by it, this should be allowed to subside entirely before the operation is repeated, using emollient and sedative injections in the mean time. Among the effects distinctly traceable to irritation caused by the introduction of sounds, more particularly through the deep urethra, is a peculiar fever, termed *urethral fever*.

In many cases, however, in which I explore the urethra, I do not pass the instrument *into the bladder*, for the reason that stricture is very seldom situated near the bladder. I cannot be too emphatic in warning you to keep out of your patient's bladder. Do not enter it even for exploratory purposes, unless you think it absolutely necessary to do so. First explore the anterior urethra and relieve as far as practicable any abnormal condition that may exist there. Keep out of the bladder if possible. It is the disposition of the profession all over the world, when exploring a urethra or dilating a stricture, to pass the instrument on into the bladder. Now, there is absolutely no danger in passing an instrument gently down to the membranous junction, but there is always danger in passing an instrument beyond that point on into the bladder. Death has occurred in more than one instance from suppression of urine through a reflex irritation, caused by gently passing a bougie into the bladder, where disease of the kidneys and bladder was present. I have known

many cases of swelled testicle that occurred simply from the passage of a sound through the deep urethra, and at least one case where the loss of a testicle was directly due to introduction of bougies for dilatation of stricture, thus setting up an orchitis which finally ended in an abscess which destroyed that organ.

Urethral Fever.—This consists of a rigor, more or less severe and prolonged, followed by a temperature sometimes up to 105°, and this is succeeded by a sweat, altogether exactly like an attack of malarial fever, and this not infrequently succeeds the passage of an instrument through an urethra, unusually irritable from any cause, the chill coming on from one or two to twenty-four hours after the instrumentation. In persons of malarial habit, it is most frequent, and unless treated vigorously by quinine, may recur like an ordinary quotidian.

It is important in connection with the subject of urethral fever to be aware that the same causes which induce it, or the nervous disturbance caused by the attack, may, through reflex irritation, produce a partial or complete *suppression of urine*. This is most likely to occur in cases complicated by organic disease of the kidneys. Harrison, of Liverpool, has called especial attention to the danger of its occurrence in elderly men who habitually pass large quantities of pale urine. Such an accident calls for prompt revulsive treatment by dry cupping over the loins; turpentine and hot-water stupes, and the galvano-faradic current is also claimed to be of service in restoring the excretory function of the kidneys. In my own experience, a large dose of calomel, twenty to thirty grains, has on several occasions acted promptly in producing this result.

In view of the possibilities of urethral fever and the other troubles which have been alluded to as occasioned by the passage of instruments through the deep urethra, more especially in elderly people, or those in which the urethra is especially sensitive, it is wise to administer quinine, five or ten grains in such cases, by the mouth or in suppositories, at least one hour or two previous to the attempted introduction of the instrument, for in this way, and with suitable rest (preferably in bed) from twelve to twenty-four hours afterwards, the danger of such troublesome consequences may be reduced to the minimum.

JABORANDI LOCALLY APPLIED IN ECZEMA.—Dr. Robinson, of Trinidad, Cal., writes to the *Therapeutic Gazette* that, having used fl. ext. jaborandi in erysipelas with good results; he has tried it in eczema in two cases, and found that it gave prompt relief from the itching, and benefited the disease. He applied it in its full strength.

CIRCINATE ERUPTION OF THE TONGUE, CALLED "GLOSSITE EX-FOLIATIVE MARGINÉE" (LEMOIMIER), "ETAT LICHENOIDE" (GUBLER), "LA SYPHILIS DESQUAMATIVE DE LA LANGUE" (PARROT).

BY

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MY first case of this rare and peculiar disease is that of Annie T., age 7 years; patient had measles when four years old, also whooping-cough; had a severe attack of bronchitis last winter, which confined her in-doors for several weeks.

In February of the present year, she was brought to me by her mother on account of "curious rings or spots" on her tongue, which her mother was informed was ringworm.

The mother of the child thought these spots were ringworm, because a little girl whom Annie usually played with had similar spots on her tongue, and also ringworm of the head.

Annie T. had three of these rings on her tongue, which were situated on the tip of the upper surface and each side of the tongue, and extended towards the median line or raphe of the tongue, at which point the spots extending from the sides coalesced, thus causing the ring-like appearance to fade away into irregular contour.

The spot on the tip of the upper surface of the tongue presented a most striking appearance of a ring as seen in ringworm cases, and was the most typical ring of all.

The other case was that of Lillie A., age 6 years, who was brought to me for ringworm of the head, and for the "rings" on her tongue.

She had two rings extending from the sides to the median line of the upper surface of the tongue, at which point the rings coalesced, forming a ring of irregular contour.

The mother thought these rings on the patient's tongue were ringworm, on account of that disease being present on the child's head.

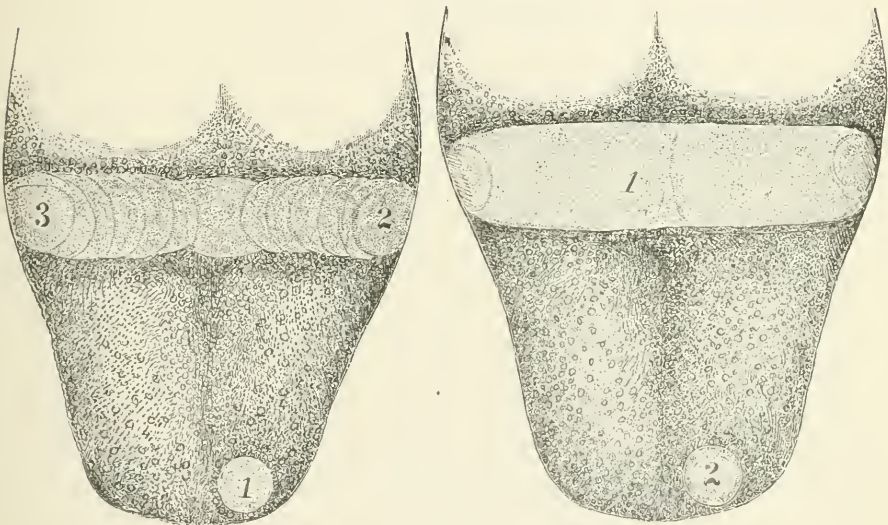
The mother informed me that the rings on the tongue appeared about a week after she noticed the ringworm on the patient's head. The cause of the ringworm on the head was not known for a certainty, but was thought to have been caught at school.

These two are the only cases of this disease that I have seen in this country, but I have seen several examples of this rare affection in Europe, most of which I saw in the clinic of Dr. Colcott Fox, of London.

In some of the cases, the children were brought to the hospital for these "spots" only, the mother, as a rule, supposing them to be ringworm; in a few cases the children had, in addition to these spots on their tongues, ringworm on the head, for which they were brought to the hospital.

These spots or rings on the tongue were present in several cases where there was no ringworm affecting the patient. A little girl was brought to the hospital to be treated for otorrhœa who had this peculiar affection of the tongue.

On questioning the mother about this condition of the child's tongue, she said she did not pay any particular attention to the appearance of the tongue, as the rings would come and go frequently.



In one family there were two cases of this affection of the tongue, in children aged respectively four and six years, the eldest child having, in addition, ringworm of the head.

In these two cases, according to the mother's statement, the rings on the tongue appeared one week after she noticed the ringworm on the patients' heads.

It seemed to be the rule that, in the majority of cases where these rings on the tongue and ringworm of the scalp were present in the same patient, that the latter affection was noticed first, and a few days later the affection of the tongue appeared. Dr. Fox says that, in his experience, this disease is uncommon in England, he having met with but a dozen cases within the past ten years.

As to the frequency of this affection in this country I cannot speak, as I have only met with the cases above reported.

This peculiar affection of the tongue has been noticed by several physicians in Paris.

Gubler noticed this disease as far back as 1869; it has also been noticed by MM. Bridon, Barthéz, Lailler, and other eminent French writers. This affection has also been observed in England by Dr. Colcott Fox, Sir James Paget, and others.

The appearance of these rings on the tongue is very similar to that of ringwood of the body generally. Whether this affection is of parasitic origin is not clearly proven. I have made very careful microscopical examination in my cases, but failed to find any evidence of the presence of the trichophyton fungus. Very careful microscopical examinations were made in several cases at the Victoria Hospital for Children by Dr. Fox, who failed to find any fungus present.

Dr. Fox says that he has repeatedly examined all parts of the affected tongues with great care, but has not found the trochophyton fungus present in a single case.

Parrot considered this affection to be due to syphilis; but Dr. Fox, who has made a careful study of this affection, concludes that syphilis was not the cause of this disease in his cases.

In my own two cases, syphilis was in no way connected with the cause of the disease.

Gastro-intestinal disturbances are considered by some as the cause of this affection.

Mr. Clement Lucas, of Guy's, has demonstrated this affection in a syphilitic child.

I have seen in the clinic of Dr. Colcott Fox syphilitic eruptions, both hereditary and acquired, on the tongue, but these were certainly different in character from the rings on the tongue as illustrated by above cases; and I think close examination of these so-called "rings" on the tongue, and the syphilitic lingual eruptions, which are sometimes circular in appearance, will distinguish two conditions entirely different from each other.

The cases in which I observed this affection were in children, and the majority were females. This affection has been observed at periods of life varying from childhood up to adult life. Vanlair thinks it occurs mostly in females.

These rings or patches vary in size from a lentil upwards, and begin, as a rule, on the sides and upper surface of the tongue, spreading toward the centre or median line of the tongue. The centre of these "spots" is red and shining, and has a raised white border.

These rings last four or five days, and other rings appear before the

first have entirely passed away. This disease is generally considered an affection of childhood.

As regards treatment, very little is given, except to meet symptoms present: if the affection is due to gastro-intestinal troubles, this condition must be remedied; if due to syphilis, adopt the necessary treatment. In my cases the affection disappeared without any treatment.

DERMATOSES PRODUCED BY DYE STUFFS.

BY

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THE statement has been made¹ that aniline dyes will not cause irritation of the skin, even in workmen whose face and hands are constantly covered with them, that the dyes are then in a soluble form; the conclusion follows that dyed stockings, etc., will not cause inflammation of the skin, for the colors are then in as insoluble a form as the dyer can make them. It is further said, in the year 1872, arsenic was found in magenta, with which the hosiery was dyed in 6.5 per cent, but that the highest quantity is now under 0.09 per cent.

This may be true of hosiery manufactured at Nottingham and Leicester, to which Mr. Ashwell refers, but it certainly is not true of all dyed stockings. Dr. Edson, of the New York Health Department, has called attention to the danger of wearing certain kinds of colored stockings. The dye, on analysis, was found to contain poison—quantities of arsenic and antimony. It has occurred in the experience of nearly every physician to meet with cases of skin irritation directly traceable to the dye in the patient's clothing; but every one is not equally susceptible to the influence of these irritants; because a certain dye-stuff will cause a dermatitis in one individual, it does not follow it will cause it in every case. I opine there must exist a condition of the skin that is predisposed to take on inflammation from certain kinds of external irritants. A number of individuals may be exposed to the same influence, a few will be affected, while the others may subject themselves to such irritants with impunity. This is known to be true in the cases of eczema, the parasitic diseases, and dermatoses produced by rhus poisoning.

I now have a patient under observation who has a severe inflammation of the skin, caused by being in the neighborhood of poison ivy,

¹“Dyed Hosiery and its Relation to Skin Irritation,” by Mr. J. R. Ashwell, New York Medical Record, Nov. 20th, 1886.

though he denies having come in contact with the plant. Others may even handle it with impunity.

The eruptions produced by dye-stuffs are very similar to those caused by poison oak; they may be of an erythematous, vesicular, or pustular form; they have special characters by which they may usually be distinguished; the coloring matter is usually still visible on the skin when the patient comes under observation. They differ from eczema in not being diffused over the surface. Produced solely by local causes, they are limited in extent; the pruritus is not usually as severe; they are limited in duration, and have no tendency to recur. The vesicles, if present, are larger, more distended with serum than in eczema.

As the literature upon this subject is so meagre, it may be of some interest to report a few cases I have recently had under observation.

CASE I.—Mr. C. presented himself at my office, complaining of a severe inflammation of the hands that had made its appearance some days previously. The subjective symptoms were rather of a burning, painful nature than pruriginous; the eruption, extending from the ends of the fingers to the wrists, was of a vesicular form, each vesicle about the size of a pin-head, the skin of a bright-red color. On examining the surface closely, the discoloration was noticed to end abruptly around the wrists. On inquiry, it was ascertained he had been wearing gloves with a bright-red lining. They were warmer than he had been in the habit of wearing; in consequence, the hands had been bathed in moisture from the profuse sweating. After discarding the gloves, and using a simple dusting powder, the eruption soon disappeared.

CASE II.—Mr. H., a tailor, complained of an acute dermatitis of the face and hands. He believed the condition had been brought about by handling certain kinds of colored goods while occupied in his business. He had of late been careless in his toilet, and had allowed the dye to remain on his hands for days at a time, till they had become much inflamed and very itchy. He had then tried to wash it off, but, as he expressed it, "the stuff became imbedded in the skin, and washing was no good anyhow." The face and hands were covered with an erythematous rash, and were very much swollen. The eyelids were nearly closed. He made a good recovery within two weeks, after thoroughly washing the parts with soap and water, and applying a lead and opium lotion.

CASE III.—Mrs. M. reported she had been subject to attacks of eczema all her life. About a week previous to her visit, an eruption had appeared on the feet and toes that had caused her much annoyance, not only from the burning sensation in the parts, but from the extremely disgusting odor. She had never been troubled with bromidrosis. The feet and toes were found to be covered with a vesicular eruption, the skin between the toes highly inflamed in some places. The epidermis had

peeled off, leaving a raw, exuding surface, the parts stained of a bright-red color from her stockings. She had never before had an eruption about the feet. She was advised to discard the stockings, and apply diachylon ointment, separating the toes with pieces of lint smeared with this ointment. The patient was not seen again for several weeks, when she returned, saying the rash soon disappeared after she had substituted *red* stockings with white soles, but that now it had made its appearance about the legs and knees. She was now advised to wear plain white stockings, when she was soon relieved from any further trouble. In this case, there can be no doubt that the inflammation was caused by the dye acting as an irritant in one predisposed to attacks of eczema.

CASE IV.—Patient affected with a rash very similar to that in Case III., but he had never worn colored stockings. The parts itched excessively; had never had any form of eruption till this made its appearance a few weeks before; had been treated for eczema for some time without benefit. His shoes had red linings, and his stockings were slightly stained with the dye. He was relieved in a few days by means of oxide of zinc, and starch powder.

CASE V.—Boy 15 years of age, with a diffused scarlatiniform rash extending from the neck to the buttocks. No subjective symptoms. Color did not disappear on pressure. Ended abruptly against the margin of the healthy skin. He was wearing a red undershirt that had never been washed. The eruption disappeared within ten days after discarding the shirt.

Dr. Putnam, in the May number of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, reports a case of erythema venenatum caused in the same way. In this case, the rash was accompanied with sore throat and fever, rendering the diagnosis somewhat difficult.

The last case I would report is a personal experience. After wearing red fleece-lined gloves for several days, I was troubled with an eruption about the hands and fingers; the itching was severe, so much so, the parts were much excoriated from scratching during sleep. The hands were stained a bright-red color which could not be washed off; a few vesicles between the fingers. A lead and opium lotion soon relieved the condition.

STIGMATA MAIDIS IN THE ACUTE STAGE OF GONORRHOEA.

—Dr. Stuver, of Rawlins, Wyo. Ter., writes to the *Therapeutic Gazette*, December 15, 1886, that he has found fluid extract of corn silk of positive value in allaying the pain and irritation of acute gonorrhœa. He has used it for the past five years in painful affections of the kidneys and bladder, and published an article on its "Anæsthetic and Diuretic Effects" in the *Med. News*, of October 6, 1883.

He gives a drachm of the extract in water combined with about ten grains of acetate of potassium every two hours in the acute stage of gonorrhœa.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

167TH REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. FOX presented the following case:

Mrs. G., native of Ireland, 50 years of age. The disease began many years ago, how many is not clearly stated. History negative in regard to syphilis. No miscarriages. Bowels constipated. Has rheumatism very badly.

Disease began above the left knee as a patch about the size of a gold dollar, and spread from there, so that now the whole anterior and lateral sides of the leg, as far as the ankle, are covered with a red, dry, scaly patch, having a well-defined papular margin. The sole of the left foot has its epidermis thickened, and presents circular depressions here and there as if a corn had been pulled out. Right leg is sound. Eczema of both hands exists, with thickened and fissured palms.

The case was regarded by all present as one of rheumatic eczema of a rather peculiar type.

DR. TAYLOR presented a case of

CHRONIC INFLAMMATION OF THE EXTERNAL GENITAL APPARATUS OF A WOMAN.

Microscopic sections of the lesion showed granulation tissue.

DR. STURGIS spoke of two cases of tubercular ulceration which had occurred in his practice: one of nine years' standing, which had begun as a chancre, and in which auto-inoculation had been practised successfully. The patient apparently had no tendency toward phthisis; there were no glandular complications, but the ulceration refused to heal. Finally, tubercular phthisis developed, and caused death. In the second case, which occurred also in a male, and was similar to the first, phthisis developed in the same way.

He should expect to see Dr. Taylor's case develop phthisis.

Dr. Sturgis said he regarded phthisis of the lungs secondary to the local tubercular disease, the tubercular tendency being the cause of the ulcer not healing. The chancre was converted into a chronic tubercular ulceration.

DR. TAYLOR said the tissue composing the growth in his case was exuberant, and not ulcerative.

The microscopic section of a portion of the growth in Dr. Taylor's case was examined by all present, and found to consist of an aggregation of round cells, without any histological features which would make a microscopic diagnosis positive. Further discussion was postponed until the next meeting.

DR. TAYLOR then read the paper of the evening entitled:

"THE MODE OF DEVELOPMENT OF MOLLUSCUM FIBROSUM."¹

DR. SHERWELL criticised Dr. Taylor's use of the term "wart" in describing some of the changes occurring from prolongation of the molluscous tumors, in view of this word being so intimately connected with epithelial proliferations; and also in view of the perfectly well understood term "fibroma pendulum."

DR. S. suggested as an explanation of the apparent invagination of the tumors

¹ See page 41.

spoken of, that it might be due, not so much to the alleged fenestrated condition of the true skin in the sites of the bases of the tumors, as to a thinned condition of the skin itself, and also owing to the semi-liquidity of the embryonic fibrous cells; that this mass, on being pressed upon, might seem and act almost similarly as in the pitting oedematous tissue; being, however, owing to the more fully developed character of some of the fibre cells, etc., more resilient. As to the so-called resorption or subinvolution, it was common in other fibrous structures with advancing age, and in some cases, what may appear like it, might be caused by hardening and contraction in some of the older portions of tumor, giving the feel to the tumor of the angle-worm variety, to which the author compares some of them. He agreed with Dr. Taylor that the case shown at a former meeting, and referred to in his paper, was indeed noteworthy, and that it certainly gave support to the theory advanced and advocated by himself and others.

DR. BRONSON asked Dr. Taylor if he would apply his theory to multiple fibromata. Dr. Taylor said he did not attempt to.

DR. STURGIS asked if the growths started as neuromata. Dr. Taylor said no. There was wounding of a territory of skin, and for ten years a general infiltration without pain or anything to point to neuroma, and the microscope showed only dense fibroid tissue.

In hard fibroid, the tumors go on increasing in hardness, the tissue which was compressible becomes resistant. Generally the harder tumors are in the older persons. He would be glad if some one would suggest an appropriate name for these growths. He said the pouches show no evidence of papillæ. Dr. Sherwell said there was a subinvolution which took place in the tumors which was mentioned by Kaposi and others. The semi-fluid or soft part consisted of embryonic cells, and reabsorption takes place. The skin is dilated and expanded, and finally the natural structure of the skin is destroyed at the spot.

DR. BRONSON asked the writer's opinion of acrochordons or the pedunculated tumors which developed about the face, having found a variance of opinion in authors, and would like to know if such a disease, distinct from fibroma, existed. Dr. Taylor said there was a class of growths found upon the trunk of children called mother's marks, berries, etc., in which the color changed at different times of the year. They were due to intra-uterine proliferation of tissue, and the same thing happens to them in intra-uterine life as in the mollusum fibrosum described. The central part consists of a hole and not of oedematous tissue. He said that the clinical history of mollusum fibrosum was not given in any book he had been able to find. He had attempted to give the clinical history of these tumors as such, as those mentioned by Dr. Bronson under the term acrochordon. The changes from the soft to the hard tissue goes on very slowly.

DR. KEYES asked if any of the members present had seen a case of seborrhœa extending upon the mucous membrane of the lips. He had a case under treatment in which a seborrhœa involved the nose, cheeks, and chin, and extended upon the lower lip, causing extensive exfoliation of the mucous membrane and an oozing out of a gelatinous substance, producing a crusting in consecutive layers, until it stood out an inch or more from the lip, and then fell off. It was an exfoliation of the tissue and not a desquamation. There was no other eruption present upon the body.

Hutchinson has said that he had seen two cases cured by the solid stick of nitrate of silver. Besnier saw two cases, and said they were seborrhœa.

Scarification had been recommended, but no patient would be likely to submit to it.

DR. MORROW, who had seen the case, doubted the propriety of the designation of seborrhœa of the lip; the morbid process was most active and apparently centred in the vermilion border of the lip, where the existence of sebaceous glands had not been demonstrated.

DR. TAYLOR asked if there was a continuity of disease between the seborrhœa of the face and the disease of the lip.

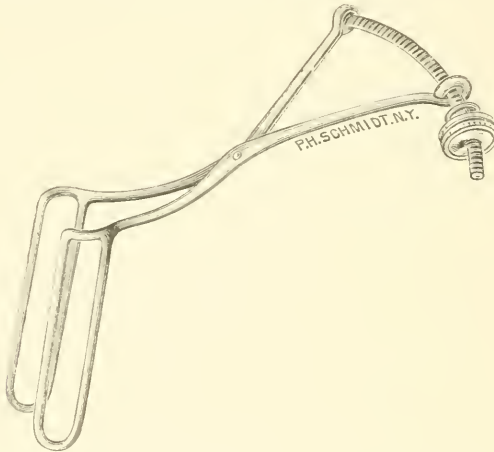
DR. KEYES said there was, and that the disease had existed for two years; the lip was tense and engorged, but there was no inflammatory element present. The upper lip had been involved, but was now clear.

DR. BRONSON said there was never seborrhœa without accompanying keratosis. It was so upon the scalp. Hard scales, like those of psoriasis, were found upon the scalp and elsewhere, forming seborrhœa sicca. It was not impossible that a keratosis could affect the lip, a region devoid of sebaceous glands.

DR. TAYLOR exhibited

A MEATOSCOPE,

which is figured in the cut of natural size. It consists of two fenestrated blades which are separated by two thin, but strong arms of steel, which are separated by means of a screw, which works upon a curve. Besides the present size, by which the urethra may be explored for rather more than an inch, there is a smaller one, the blades of which are one-half the length of these. By the use of either, which are very light and easy of adjustment, examinations and applications to the anterior portions of the canal can be satisfactorily made.



DR. MORROW asked if the peculiarity of the new instrument consisted in the form of the blades or in the mechanism for expanding them. The blades were identical with those of Sims' rectal speculum.

DR. TAYLOR answered that it was in the application. The Folsom apparatus is held by a powerful spring; its use is painful, and the instrument is large.

Skene's speculum, made on the principle of the Sims', was also painful of application, the principle is here the same, but the application different.

DR. STURGIS asked if the mucous membrane did not get into the blades—an objection he had found to the Folsom instrument.

DR. TAYLOR said this did not happen in his instrument.

Correspondence.

DOSE OF ARSENIC IN SKIN DISEASES—CORRECTION.

To the Editor of the Journal of Cutaneous and Genito-Urinary Diseases.

DEAR SIR:—I notice in the December number of the JOURNAL that you give me credit for rather heroic treatment with arsenic (page 374). What I wrote is that in the ordinary adult case I jump into it at once with *ten-drop doses three times a day for four to six days, and then drop down to smaller doses, three to six drops*. My object is to get the system affected with the medicine at once, and then keep the effects up by such doses as are bearable and safe. I never gave as much as ten drops of Fowler's solution four to six times a day.

I have found patients where two to four drops have irritated the stomach. My experience with solutions has been more favorable than with the arsenic in pill, being less likely to disturb the stomach. Once I undertook to swallow an arsenical pill and it stuck in my throat and would not budge another inch. Of course, it corroded the mucous membrane of the gullet, from the effects of which I did not recover till the end of several weeks. Some years ago, I had a very severe case of *psoriasis guttata*. There was a great amount of spattering of the body and neck, and some other parts were much congested. The late Dr. Durkee, of this city, saw it and thought it could not be cured. On account of the activity of the skin lesion, I did not use arsenic, but the bichloride of mercury internally, and externally the nitrate-mercury ointment in solution of sweet oil. This case recovered much sooner than I expected. I formerly treated many more cases of eczema than I now do, and in many of them I used arsenic.

The mucous membrane and the skin have such a close sympathetic relation, it is not to be wondered at that many varieties of skin disease should spring from disordered bowels. The beneficial influence of arsenic on the mucous surfaces may be the reason of its success over certain eruptions of the skin dependent upon the bowels, while in the same form of eruption not so dependent it is of little or no value. I once tried it in a case of chronic urticaria with not the slightest benefit, the urticaria not depending upon the stomach, but rather upon disturbance of the uterine functions.

That it is a powerful alterative, or possibly a tonic to the nerves, is shown by its reliable effects upon other forms of disease having marked nerve symptoms. It stands to reason that it should also be useful in skin affections influenced by or depending upon neurotic conditions. In some such cases, especially when there is anaemia, its use in conjunction with iron gives a success not to be reached by iron or other tonics.

Very truly,

E. CHENERY, M.D.

BOSTON, MASS., 63 CHANDLER STREET.

Reviews.

TRAITÉ PRATIQUE ET DESCRIPTIF DES MALADIES DE LA PEAU, par ALFRED HARDY, Professeur de Clinique Médicale à la Faculté de Médecine de Paris, Ancien Médecin de l'Hôpital Saint Louis, etc., etc. Paris: J. B. Bailliére et Fils, 1886.

As is well known, Hardy for many years enjoyed the distinction of being recognized as the leading representative of dermatology in France. Probably no one, not even Bazin, who divided with him the honors of the Saint Louis Hospital, has made a more distinct and profound impression upon French dermatological thought and doctrine than the distinguished author of the work before us.

As stated in the preface, having been for twenty-two years physician to the Hospital Saint Louis, and having devoted twenty years to the clinical teaching of diseases of the skin, he considered himself possessed of the experience necessary to write a book on dermatology.

The author's evident appreciation of the necessity of mature and prolonged preparation for such a work may seem superfluous in this country, judging from

the precipitancy with which text-books on dermatology have been launched by writers of comparatively limited experience.

After examining this imposing volume of 1,228 pages, which is presented as a "complete and didactic treatise on dermatology," no one can question the eminent fitness of the author for this task. It certainly is a complete and exhaustive exposition of the principles and practice of dermatology as taught by the eminent master to more than one generation of pupils. It is peculiarly and essentially expositive of the diathetic doctrine of skin diseases, as opposed to that of the Vienna school.

Dermatology, the author claims, is still a French science. "There exists," he says, "relatively to cutaneous affections, a French doctrine; abroad, principally at Vienna, under the influence of the school founded by Hebra, the greater part of the eruptions are considered as local diseases and independent of all general causes; in France, on the contrary, they are regarded as connected with general morbid conditions of which they are only the expression, and this tendency to subordinate diseases of the skin to a primordial diathetic cause, innate or acquired, already taught by Alibert, is more and more pronounced among us, notwithstanding certain regrettable defections, etc."

While the author thus traces a fundamental distinction between the French and Vienna schools in their etiological conception of cutaneous diseases, he ignores the fact that, within the last decade, what may be termed a new school of dermatology has sprung up in France which has departed from the traditional doctrines. To-day the nosological views of Hardy and Bazin are by no means accepted unqualifiedly and without reserve.

Besnier, Vidal, Doyon, and the brilliant body of younger specialists, whose admirable work and teachings have shed additional lustre upon the time-honored St. Louis Hospital as a centre of dermatological instruction, represent broader and more progressive views. For them the dermatological horizon is not limited by narrow national lines; they recognize the universality of science, and they have shown by their translations of German and American works, and their assimilation of new ideas from these sources, a generous appreciation of the work done by foreign dermatologists.

While they do not deny that many diseases of the skin are connected with a general pathological state, yet they by no means accept the paramount influence of certain diathetic predispositions in their causation. To many of the modern school the very terms employed to express these conditions are intrinsically meaningless. The assumption of the existence of "herpetism," "arthritism," etc., as determining causes of the large proportion of cutaneous affections, is rejected as chimerical and utterly devoid of a scientific basis. As a result of recent researches, the Samson of scrofula has been shorn of his locks; many cutaneous lesions, formerly attributed to this diathesis, are now recognized as the manifestations of syphilis or the offspring of tuberculosis.

When, therefore, Hardy eulogizes "*Bazin et moi*" as the authoritative exponents of dermatology in France, he detracts from the well-earned reputation of a younger generation of dermatologists, whose original researches and anatomico-pathological investigations must be ranked among the most valuable contributions to our knowledge of cutaneous pathology. This failure to recognize the notable and important acquisitions made by his successors, since his withdrawal from active work in this special department, constitutes the chief defect of the work.

But, while criticising the evident disposition of the author to magnify the claims of Bazin and himself, and to unduly exalt the importance of certain

diathetical doctrines, now obsolescent, we by no means wish to disparage the general excellence of the work before us. It is the work of a master whose large experience and thorough familiarity with the subject, combined with a facile talent of expression and a singularly attractive style, have enabled him to produce a book which is a credit to himself, and an honor to the school of which he was for so long the acknowledged head.

OUTLINES OF THE PATHOLOGY AND TREATMENT OF SYPHILIS AND ALLIED VENEREAL DISEASES, by HERMAN VON ZEISSL, M.D., Late Professor at the Imperial Royal University at Vienna. Second Edition. Revised by MAXIMILLIAN VON ZEISSL, M.D., Privat Docent for Diseases of the Skin and Syphilis at the Imperial Royal University at Vienna. Authorized Edition, Translated, with Notes, by H. RAPHAEL, M.D., Attending Physician for Diseases of the Genito-Urinary Organs, Bellevue Hospital Out-Door Department, etc. New York: D. Appleton & Co., 1886.

The publication of a translation of the second edition of Zeissl's work has placed at the disposal of the profession of this country an admirable treatise on the pathology and treatment of syphilis.

The author's object, he avers, was to present a book which should serve as a guide to the student in the study of syphilis, as well as to the practical physician whose time will not permit him to read extensive works upon every special branch of our science. With a thorough comprehension of what such a book should be, he has endeavored to adapt it to the purpose in view by the sacrifice of unnecessary details and the omission of all matter of merely theoretical importance, while giving a special prominence to the pathology and clinical description of the various phases of the different diseases which he comprehends under the above title, viz., gonorrhœa, chancroid, and syphilis.

Zeissl's extensive experience, based upon the observation and treatment of over thirty thousand patients in private and hospital practice, has furnished unrivalled opportunities for the clinical study of the various phases of these diseases, and the motto of the book might well be *quæ scripsi, vidi*. Although the author does not aim to present anything new, yet the skill and fidelity with which the clinical pictures are traced, and the clear and graphic style of his descriptions, give to the book much of the charm of novelty.

Without attempting to enter into an analysis of the various parts of the work, we can cheerfully commend it as a clear, concise, yet sufficiently comprehensive exposition of the subjects of which it treats.

In the matter of the therapeutics of syphilis, Zeissl's views differ in many essential particulars from those generally entertained by syphilographers of the present day, especially in this country.

While conceding the efficacy of mercury in causing the symptoms of syphilis to disappear, he commits himself unqualifiedly to the opinion that early mercurial treatment is not only useless, but is positively pernicious, exposing the patient to a greater liability to relapses, while subjecting him to greater risk of grave lesions in the shape of cerebral and visceral accidents.

His method of the treatment of syphilis may be thus briefly outlined. The treatment of the initial lesion is directed solely with the object of hastening the cicatrization of the sore. This object is best accomplished by keeping it clean, and the application of iodoform and the emplastrum hydrarg., with the use of mild caustics in exceptional cases. The destruction of the chancre by caustics or excision, with the view of aborting syphilis, is considered useless.

"The expectant plan of treatment should be pursued for eight weeks after the appearance of constitutional symptoms. If the symptoms of the disease have not entirely disappeared at the end of eight weeks, or if no improvement is perceptible, we then prescribe preparations of iodine.

"If the symptoms of the disease have not entirely disappeared after the expiration of eight weeks more, the treatment of mercury may be resorted to. Our favorite remedies are Zittmann's decoction and inunctions of blue mass. By pursuing the course mentioned, a smaller number of inunctions are necessary to cause the symptoms of the disease to disappear than if a mercurial treatment is instituted from the beginning. We seldom employ mercury subcutaneously or administer it internally."

"Iodine in proper quantities, in conjunction with a carefully regulated regimen, are sufficient to cause the symptoms of syphilis to disappear, or, at least, to be weakened so that only a few mercurial inunctions will be necessary to complete the cure without fear of a relapse occurring in years to come."

While the author's depreciation of mercury and his exaltation of the value of iodine, which he declares is adapted to "*all phases of syphilis*," have not met with general acceptance, still, in view of his phenomenally large experience and his conscientious record of the results of treatment, it must be admitted that his opinions are entitled to great consideration.

Selections.

HABITUAL HYPERIDROSIS PEDUM AND ITS TREATMENT.

It is a fact, not yet widely enough known and not sufficiently appreciated, that hyperidrosis of the feet is an affection so frequently existing that perhaps every third or fourth person encountered is troubled with it to a greater or less degree.

It occurs in both sexes from earliest childhood to ripe old age, but seldom beyond the age of seventy, because those who are severely affected by the disease seldom exceed that age. Otherwise perfectly healthy individuals are as frequently the subjects of the disease as are dyspeptics, chlorotics, anæmics, and neuropaths. Especially in those of a choreic or sanguineous temperament, do we find at times the sweating more profuse on one foot than the other, and again on the front part and between the toes greater than above the heel, and vice versa.

Strangely enough, most persons thus affected, even those of the upper classes, are not aware of it. This is more especially true of the disease in its milder grades.

Coldness of the feet is a characteristic of the trouble in those who stand or sit in cold rooms, or in travelling, etc., and many of these patients wear thick woollen or felt stockings, and woollen or felt shoes. It often happens that one thus affected, after being all day in the cold and wind, and having lost much bodily heat will, upon going to bed, have a marked chill, continuing until the bed is well heated by his body.

Hyperidrosis pedum, as well as general perspiration of the body, is dependent upon the mode of life of the individual to a very great extent. Thus we find it most frequently and in its severest form in those who live well and take little

exercise; in those who begin the day with a glass, eat a hearty midday meal with wine, and follow it with coffee; and in those who begin their day with the evening. We find hyperidrosis pedum also, however, in those who lead a regular life, especially in young women of a somewhat nervous temperament, who regularly each day pay their allegiance to the pernicious habit of frequent tea and coffee drinking. Here sweating of the hands is usually associated with that of the feet. Another cause of the affection is to be found in the topographical situation of the feet so to speak. In most men the feet have probably the greatest amount of muscular action, both active and passive, to perform, and consequently an increased blood circulation both in and toward them, and the return current of venous blood has the longest and most difficult journey back towards the heart. Now this return flow is often greatly hindered by the foot covering, especially in women who wear low shoes with a tight band across the instep or ankle. The form of foot covering is of great importance, and it is readily appreciated that a boot reaching about to the middle of the calf, and having wide tops, offers better chances for ventilation and evaporation than do shoes either of the buttoned, laced, or of the elastic gaiter variety. The inside sole should be rough rather than smooth, and should not be glued down with starch paste.

In many cases, the cause of this local excessive perspiration is entirely unknown, and equally true is it that we are unable to account for the sudden and complete disappearance of a hyperidrosis which has lasted for years. Aside from being an extremely disagreeable malady, it is a dangerous one for the general health and one often followed by serious results—a fact not sufficiently dwelt upon. It will not be difficult to demonstrate this with our knowledge of the physiology of animal heat, and the consequences of general or local cooling of our bodies, when this knowledge is associated with observations and experiences of every-day practice. Every man will acknowledge that, so far as heat effect is concerned, it makes no difference whether our stockings are wet with our own sweat or in an equal degree from a puddle in the street—wet is wet. When the skin is in contact with a surrounding medium, especially a moist one, it will give off heat as long as the temperature of the body or the member exposed is higher than the surrounding medium, and the more the medium will take up the more will be given off. Thus those suffering from this complaint are apt to have a chronic loss of bodily heat. It is well known to all how dangerous to the health it is to have wet feet,⁴ even for a few hours. How much more then must this be the case when, from hyperidrosis pedum, the feet are day after day, year in and year out, wet so much of the time? It is not rare that such persons, for hours and days together, have not only their feet, but their legs as well icy cold. The strongest organism cannot stand this chronic loss of heat, in youth any more than in the later years of life, when the temperature of the body diminishes. Before his fortieth year, a man who has suffered from hyperidrosis pedum will have vague rheumatic pains, a general indisposition, an uneasiness without any apparent cause, a diminution in mental and bodily power of exertion. He grows old before his time, becomes rheumatic, and is seldom free from catarrhs. It would be interesting to observe the bodily temperature of a large series of cases of hyperidrosis pedum before and after the cure. Winternitz was the first to show that a thermometer, placed in the external auditory meatus during a cold foot-bath, recorded after ten minutes a fall of temperature of from half to six-tenths of a degree C., which he explained as a reflex effect of the skin irritation upon the vessels and circulation in the head. I have often observed that, especially in women, the much dreaded migraine would regularly follow a decided cooling of the feet, and in one patient I have often

succeeded, when the cold had not been too prolonged or excessive, in cutting short an attack of migraine with a foot-bath of 38° or 40° C. reaching above the calves. The public has been inclined to look upon hyperidrosis pedum, when it has given the subject any attention at all, as something which, if interfered with or arrested, would act injuriously upon the general system. Thus it has happened that the dermatologists are almost the only ones who have treated the complaint, and they have been called upon to treat it principally on account of the annoyance its presence has caused. Treatment has usually failed, because, as I believe, up to the present time no one has pursued a rational and radical method. I have faithfully tried all the remedies recommended in the text-books without success, and have given powdered white agaric, arsenic, aconite, and atropia all a faithful trial. The latter in strong alcoholic solution, well rubbed into the sole until symptoms of poisoning were produced, but no beneficial effects, even to say nothing of a cure. Even the highly prized ung. diachyl. of Hebra, made up by different druggists and given a thorough trial, even when patient kept his bed, was found to be useless. Powdering the feet and inside of the stockings with a mixture of starch, chalk, and salicylic acid in powder, together with the application between the toes of pledgets of absorbent cotton well powdered with the same, was found useless and troublesome for the patient to do three or four times a day.

Finally, after many attempts to find a means of cure, I had my attention directed to a method of treatment, especially by the works of Röhrig, on the permeability of the skin to æthers and gases; which has promptly accomplished the much-desired result.

This substance belongs to the chloric æthers and is prepared by an especial double distillation process.

I have called it "liquor anti-hidrorrhoicus," and there will, in a short time, be published in separate work an account of it, together with the chemical constitution of these little known and little studied combinations.—DR. BRANDON, in the *Deutsch. Mediz. Zeitung*, 1886, Nos. 68, 69.

Treatment by Tartaric Acid.—The above article on hyperidrosis pedum leaves the matter of treatment in such an unsatisfactory condition that we are constrained to supplement it with details of the following methods:

Dr. Frédéricq (*Journal de Méd. et de Chir.*, December, 1886) employs finely powdered tartaric acid as a dusting-powder. At first only small quantities are applied, and great care is exercised in having the acid in a finely powdered state. A half-teaspoonful is sufficient for both feet at first, since in some persons the skin is excessively sensitive; but this dose can be increased as early as the second day. The author has recently had under his treatment a young girl whose feet were so completely macerated that the derma was exposed in many places, and walking was extremely painful. The first night the acid prevented sleep, but the next day it was re-applied without pain, and soon effected a cure. The feet should be powdered for some time after an apparent cure, and begun again when any recurrence threatens.

Treatment with Permanganate of Potassium and Lead Plaster.—Dr. Stewart (*Edinburgh Journal*) recommends this method as the most satisfactory and efficacious. After bathing the feet in hot water, they are to be soaked for some minutes in a solution of the permanganate (four to six grains to the ounce). They are to be dried, and this solution is not again employed until after complete exfoliation of the cuticle thus tanned. They are then enveloped with bands of white lead plaster extending from the roots of the toes to the ankle. Each toe

should be first covered with narrow bands of the same plaster. If preferred, lead ointment spread upon bands of old linen may be used.

The dressing is to be renewed every twelve hours and continued from ten to sixteen days, according to the obstinacy of the case and the thickness of the skin of the heel, which should be included in the dressing.

In a majority of cases, the odor notably diminishes by the end of the third day, and is not at all perceptible by the ninth; exfoliation of the cuticle takes place *pari passu* with the formation of the new cuticle, and it may not be complete before the end of the third or even the fourth week.

The strong solution of the permanganate is not applicable when there exist ulcerations or interdigital fissures.

Treatment by Eau du Goudron and Perchloride of Iron.—Dr. Legoux's treatment (*Journal de Méd. et de Chir.*) consists in foot baths of eau du Goudron, of one-half hour's duration, twice a day, night and morning.

At the end of the third day, suspension of the pediluvia and painting the soles of the feet every morning with liquid perchloride of iron.

After the fourth painting, the sudoral secretion will be found arrested, and the epidermis of the soles of the feet dry and horny.

Remarkably good results are claimed for this method of treatment, which is at the same time simple and convenient for the patient.

Treatment by Extract of Pinus Canadensis and Boracic Acid.—In the editor's experience, the best results have been obtained from the employment of foot baths of a strong solution of extract of pinus canadensis (Kennedy's) every night, and the use of powdered boracic acid, or salicylic acid mixed with lycopodium, oxide of zinc, or other inert powders, constantly applied inside the stockings. Hebra's treatment with diachylon ointment undoubtedly constitutes a most efficacious method, but the inconvenience attending its application, often temporarily interfering with the occupation of the patient, renders its employment impracticable in many cases.

FURUNCULOSIS AND ITS VARIED TREATMENT.

FEW pathological questions show more plainly the consequences to therapeutics of the discoveries in microbiology. So long as the cause of furunculosis was unknown, various modes of treatment were employed without success, while to-day, the cause being known, treatment based on etiology, which is the only rational treatment, succeeds.

The history of furunculosis can be compared with that of scabies, which, so long as it was regarded as a constitutional disease, defied therapeutics; but once its true nature was brought to light, we were in the position to cure in an hour and a half a disease which is said to have tormented, for several years, Napoleon, conqueror of Europe.

If we examine into the divers opinions expressed by writers, we find that most of the older authors believed in an internal cause.

Marchal, Prout, Cheselden, and Wagner regarded this cause to be diabetes. Kochmann attributed it to the gouty diathesis; Lailler to alcoholism.

The lymphatic diathesis, insufficient nourishment, excesses, chronic dyspepsia, senility, etc., have all been cited as causes. Nevertheless, it has always been a matter of surprise that individuals of robust constitution and vigorous health were equally liable to the affection with the weak and cachectic.

Following out the idea of an internal poison, Brodie and Guérin thought they

found singular resemblances between the furuncular eruption and variola, anthrax, and malignant pustule. Desprès ("Chirurgie journalière," 1877) was disposed to regard furuncle as an acute, gummy process, supposing that they resulted from infarction which occurred in certain points of the body in consequence of a general intoxication. It is not clear what there is in common between furuncle and gumma, for there are no anatomical analogies between these two pathological processes.

Some authors have considered furuncles as the expression of a favorable crisis in certain acute diseases.

Such local causes of irritation as friction, pressure of clothing, of the collar, the saddle in riding, added to uncleanness and the influence of dust, have been regarded by some as causative.

Furunculosis has also been looked upon at times as an epidemic disease in certain localities; but it is only at a comparatively recent date that the idea of contagion, clearly established, has come to clear up the strange features and history of the disease. In 1866, Startin (*Brit. Med. Journal*) made note of the auto-inoculation of boils, from scratching, the transmission from individual to individual in cohabitation, and from patient to surgeon from the prick of an instrument employed in opening a furuncle.

Loewenberg (*Progrès Médical*, 1880) reports a series of cases in which the contagion was undoubted; and the researches of Pasteur have demonstrated the parasite which had hitherto been only suspected. The microbe follows the hair-shaft down into the hair-follicle, and there multiplies so rapidly that a large number of glands are soon full of colonies of micro-organisms which provoke a local inflammation, either by a purely mechanical action or by the production of some irritating substance. Air and water are the vehicles of the microbes, thus explaining the more frequent appearance on the unprotected parts of the body and those exposed to the impurities of water in the daily toilet. Like other microbes, it can only develop upon a favorable soil. Undoubtedly, these micro-organisms often come in contact with, and are even introduced within our bodies, without injury, because the conditions are not suitable for their development. It can, therefore, happen that certain troubles of nutrition, constitutional changes, etc., permit the microbes of furuncle to exert an unfavorable action in our cutaneous glands. As regards treatment, Le Fort favors premature incision as an abortive means. Guérin prefers blistering. Bretonneau and Velpau extol the nitrate of silver, the stronger acids, carbolic acid, caustic potash, the acid nitrate of mercury, the chloride of zinc, etc.

Recently the acid nitrate of mercury has been employed with great success by Startin, who, we have seen, was the first to affirm the contagiousness and auto-inoculation of furuncles. He places over the boil an opium plaster, with an opening at the point to be cauterized, and, after applying the acid, he covers all with a poultice smeared with Neapolitan ointment.

Hebra advised as abortive treatment a bladder containing a refrigerant mixture of ice and salt.

Planet claims to have suppressed all furuncular eruption with a mixture of the abstract of fresh leaves of arnica and honey of roses.

The tincture of arnica and tannic acid were praised by Halle (*Cincinnati Lancet*, 1873). The repeated application, several times daily, of camphorated alcohol in the hands of Simon (*France Médicale*, 1872) gave the best results.

The tincture of iodine recommended by Boinet, about 1865, does not act differently from the camphorated alcohol, and is still more simple. It is a parasiti-

cide for the microbes as much through the alcohol as the iodine. It is to be applied in concentrated form several times a day for a few days. Pustules of ecthyma and bullæ of pemphigus associated with furuncles may themselves become transformed into boils. The practical deduction to be drawn is that all such lesions in the neighborhood of boils should be covered with a layer of the iodine.

Rüss and Boch have proposed a concentrated solution of chlorate of potassium. Loewenberg believes in puncturing with a bistoury the furuncles, or, better still, the glands in which the process is beginning, so as to expose the germs to the action of the antiseptic. It is not necessary alone that the furuncles be cured, but that relapses be prevented.

Arsenic, together with the use of alcoholics and balsams, has been much employed internally by Hardy and others, who range furuncles among the dartrous affections. The success following this treatment does not prove that it has a direct action upon the furuncles, but in improving the vitality of the organism and stimulating the nervous system, and relieving the dyspepsia, an indirect favorable influence is exerted and permits the system to become fortified and present a less favorable soil for the culture of the microbes. It is, however, by external means that we must combat and prevent boil development. Clothing once contaminated with the pus of a boil should be thoroughly disinfected before being allowed to touch the skin of the same or another individual.

Loewenberg prescribes the ablution of the whole body with saturated solutions of boric acid, which, by evaporation, leaves a deposit upon the skin, so that the effect is prolonged.

Kaposi uses for the same purpose baths containing about two pounds of alum and five drachms of corrosive sublimate. Hardy employs sulphur baths. Amongst the internal medicinal agents those which appear worthy of special confidence are the hyposulphites and the sulphurous preparations. The hyposulphite of sodium has the sanction of Duncan Bulkley, of New York. The honor of having pointed out the curative properties of the sulphides of potassium, sodium, and calcium belongs to Sydney Ringer. The dose he prescribed was six milligrams of sulphide of calcium every two or three hours. Natural sulphur waters appear less apt to produce a rapid saturation of the system than the artificial solutions. If the treatment is going to continue for a long period, it is best to begin with small doses and increase them gradually. Patients are encountered who show a marked intolerance for even small doses, either because of irritability of the digestive tract, or because the drug produces a congestion of the respiratory passages, followed at times by hæmoptysis, due to the elimination of a large part of the hydrosulphuric acid, by way of the air passages. Ringer considers the use of sulphur in the furunculosis of diabetics contra-indicated.

By associating external with internal parasitocides, we can triumph over furunculosis, which formerly caused so many healthy individuals, as well as those suffering from other diseases, to despair.—LE GENDRE (*Le Concours Médical*, Sept. 18th, 1886).

ON THE ABSORPTION AND ELIMINATION OF MERCURY IN THE HUMAN ORGANISM.

DR. WELANDER has made a series of experiments to determine how mercury is absorbed by and eliminated from the body. To the urine is added liquor sodæ and a little honey, and the mixture boiled for a quarter of an hour in a retort. Then the liquid is poured out into a glass where it is left until complete precipita-

tion has taken place. Next, the fluid is poured off, and the precipitate is placed in a glass retort. A little hydrochloric acid is added, and a piece of copper wire, three centimetres long and a half millimetre thick, which has just been heated to a red glowing heat, is placed in the retort. The fluid is now heated to the boiling point, and the opening of the retort closed with a cork, after which the retort is placed in an oven at a temperature between 95° and 149° F., and left there for thirty-six or forty-eight hours. At the end of that time the wire is taken out, dried, and placed in a thin glass tube, the opening of which is closed by melting. That part of the tube which contains the wire is heated over a very weak flame of an alcohol lamp. In consequence of this procedure, the mercury is sublimated, and deposited as small metallic globules in the upper part of the tube.

The presence of iodine salts prevents the precipitation, and they must, therefore, be removed from the urine if it contains any. The best way of doing this is to collect the precipitate formed after the first boiling on a filter, and pour a little water on it once or twice. We must not take too much water, because the mercury is soluble in water.

The test described is so fine that mercury has been found in a solution of corrosive sublimate of 1 in 10,000,000.

The experimenter must make sure that his reagents do not contain any mercury, which is often the case with hydrochloric acid.

Sometimes the globules of mercury are visible to the naked eye, but the safest way of examining them is by means of the microscope.

When mercury is given by the mouth, it appears, as a rule, in the urine one or two days later. Administered through the anus, it was already found the following day. When applied through the skin, it appeared likewise, as a rule, on the following day in the urine.

Mercury is rapidly absorbed by wounds and ulcers.

Injected under the skin, mercury is very rapidly absorbed, and appears often in the urine as early as one or two hours after the injection.

Mercury is constantly eliminated with the urine; a very great part, and perhaps the greater part of what has been introduced into the body, leaves it in that way.

The salivary glands play quite a secondary rôle in this respect.

The feces, on the other hand, contain constantly mercury, and often in considerable quantity.

Mercury is likewise eliminated with the milk, and was found in the urine of the nursing.

The elimination takes place in proportion to the amount introduced.

Welander discredits the statement of Paschkis and Vajda that mercury may remain for twelve or thirteen years in the body. He has, as a rule, found it four or six months after the end of the treatment; frequently it is found from six to twelve months, and sometimes even more than a year after the treatment has been discontinued.

Welander thinks mercury circulates in a soluble form with the blood. He found it in abundance in this fluid in every case examined. He found it likewise in pus taken from patients treated with mercury, and in ascitic fluid.

The conclusion to be drawn for practice from these experiments is, that when a rapid and powerful effect is aimed at, the administration of mercury by hypodermic injections is preferable, while for the intermittent treatment of Fournier the mercurial pills will do as well.—DR. EDWARD WELANDER, *Abst. fr. Nordiskt Medicinskt Arkiv*, XVIII., No. 2, 1886.

DIFFERENTIAL DIAGNOSIS OF PAPULO-SQUAMOUS SYPHILIDE AND PSORIASIS.

FOURNIER says (*Gaz. des hôpitaux*, No. 126, 1886) it is at times almost impossible, without the aid of therapeutics, to differentiate the two affections. Let us see upon what considerations the diagnosis depends.

They are based especially upon the volume, the color, the desquamation, the results of scraping, the consistence, the localization, the duration, the treatment, and the antecedents.

1st. *The Volume*.—In papulo-squamous syphilis, the eruption is characterized by papules, generally small or of medium size, while in psoriasis they are large, unless in psoriasis guttata, and frequently form extended plaques.

2d. *Color*.—In syphilis, the papules are of a dark red, often of a characteristic raw ham color. In psoriasis, they are rose colored or at least of a lighter red. Still both diseases often have quite a similar color.

3d. *Desquamation*.—Here we have a marked difference. Syphilitic papules are slightly and only partially squamous, often being free from scales over a large portion of their surface, and the scales are thin, small, superficial, and gray. In psoriasis, on the contrary, they are abundant, the scales cover the whole or greater part of the surface of the papule or psoriatic patch, they are large, thick, heaped-up, stratified, white, and form a laminated covering, often a true epidermic carapace.

4th. *Results of Scraping*.—In a papulo-squamous syphilide, the papules do not show, upon scraping with the finger nail, the micaceous striæ, and the *candle grease drop* (*tache de bougie*) which is characteristic of psoriasis and pathognomonic when well marked.

5th. *Consistence*.—The hardness of the papule is what I call the sign of the blind. In syphilis, the papule is resistant to the touch, hard, and gives the sensation of a foreign body inserted beneath the epidermis, and recalls the parchment induration of the chancre. In psoriasis, we find the skin simply thickened, but without hardness or true resistance.

6th. *Localization*.—In syphilis, there is no characteristic localization, no point of predilection except for the palmar and plantar varieties. In psoriasis we find, in the great majority of cases, the curious localization on the knees and elbows which is truly characteristic.

7th. *Duration*.—In a large number of cases, the duration of the eruption is an excellent sign. In syphilis, it is short in comparison to the habitual persistence and chronicity of psoriasis, and scarcely ever exceeds a few weeks or a few months, while in psoriasis it remains for months and even years; the eruption is always chronic, and this chronicity is of itself often a characteristic sign.

8th. *Treatment*.—While syphilis is in general rapidly modified by mercury, psoriasis is in no wise affected by its use.

9th. *Antecedents*.—In the syphilitic, contamination can usually be found if carefully sought for, traces of the early lesions being generally discoverable; often the papulo-squamous lesions coincide with other secondary manifestations, such as mucous patches, alopecia, etc. Nothing of this kind exists in the psoriatic, unless the two diseases be present at the same time.

OPERATION FOR PHIMOSIS IN DIABETICS.

DR. FRANCON says, in the *Lyon Médical*, No. 43, 1886, that among the complications of diabetes, there is one which is frequently observed. Indeed, at

times it is one of the first symptoms which calls attention to the condition, and has occasionally led to the diagnosis. That complication is phimosis. It was in 1807 that Bardsley first pointed out the connection existing between phimosis and diabetes. This author is cited by Marchal de Calvi in his book on the accidents of diabetes (1804). He himself had observed several cases, and Demarquay and Dubec published several observations in the *Gaz. des Hôpitaux*, 1874, p. 803. The same year there also appeared a memoir, entitled "De balanoposthite parasitaire et du phimosis symptomatique du diabète," in which Dr. Bauvais gave the exact knowledge of the question at that time. In 1876, at the Congress of Clermont, Dr. Bourgade made a communication on this same subject, and agreed with Verneuil that these cases should not be interfered with. This opinion has been adopted by Miguel-Dalton in his thesis, "Les lésions des organes génito-urinaires dans le diabète sucré," 1877, and which now is still upheld by Prof. Verneuil in various communications to the surgical society. Nevertheless, some authors have published successful cases of circumcision in diabetes, but without indicating with sufficient clearness at what stage of the disease the patients had arrived, the observations containing generally simply the explanation that the urine contained a little sugar. Dr. Francon then goes on to report the histories of two cases followed by fortunate recovery without any bad results, but, on the contrary, giving prompt relief from their intense pruritus and other disagreeable symptoms. The inconveniences of this phimosis are: The difficulty of preserving cleanliness, that the venereal desires are retained, but the pleasures much diminished; the easy production of small erosions following sexual intercourse, sensations of smarting, burning, and especially of habitual pruritus, which at times become pitiable, difficulty in urinating, and soiling of the clothing. Pruritus is a symptom in regard to which classical authors are mute. Whether we consult works on external pathology or treatises on venereal diseases, nowhere do we find a description of this sensation, so disagreeable as to deprive the sufferers of sleep, and which is the equivalent of the pruritus vulvæ of women with the same disease. The various authors who have reported observations of phimosis in diabetics have not dwelt upon the special color presented by the end of the glans penis. It is a coloration midway between a red and a violet. The consistence of the glans is quite firm, often presenting superficial erosions or slight fissures, which, however, are not as numerous as in ordinary balanitis.

The two principal symptoms are the special coloring and pruritus, which alone would permit of a diagnosis of diabetes. In 1863, Landouzy wrote that the diabetics presented *noli me tangere* complications, but after the successful cases which have been reported, including his own, the author believes that circumcision should be practised in glycosurics, all antiseptic precautions being rigorously observed. He goes so far as to claim that in diabetics phimosis should be operated upon more than in others, because of the disagreeable pruritus accompanying it, and because, under strict antiseptic precautions, its success is assured.

VULVO-RECTAL FISTULA DUE TO COITION.

A CASE of this rare form of injury was lately reported to the Obstetrical Society of Philadelphia by Dr. Joseph Price for Dr. Barton Hirst. Although, of late years, sixteen cases of rupture of the vagina have been reported as occurring during coition, only one of them, which was reported by Blumenthal, and operated on by Sir Spencer Wells in 1860, bears any resemblance to the present one, which is, without doubt, one of vulvo-rectal fistula. The patient, a young

woman of twenty-two, had been a perfectly healthy woman previous to her marriage, which took place eighteen months ago. From the first attempt at sexual intercourse with her husband her trouble began. The sexual act was followed by severe hemorrhage, which persisted for a month; the passage of fæces and flatus per vulvam was noticed at once. Every repetition of the sexual act for the next two or three weeks was followed by bleeding, and, at present, the rectum is entirely evacuated through the vulva, there being entire inability to retain fæces or flatus. Examination showed that there existed a hymen of moderate thickness and rigidity, which was perfectly intact, and having a small anterior opening. In front of its posterior attachment there existed an irregular transverse tear, about one and a half inches in its longest diameter, and extending backwards and upwards about one and a half inches, exposing to view the mucous membrane of the bowel. The edges of this tear were everted and thickened. The vagina was small, and evidently had never been entered. An operation, consisting in freshening the edges of the tear, partially loosening the hymen from its attachment, and using it as a flap to supply the deficiency of tissue, was performed by Dr. Price in March, 1886. Perfect union resulted.—*Medical Progress.*

THE TREATMENT OF CHANCROID BY SALICYLIC ACID.

THE use of salicylic acid in the therapeutics of soft chancre has been recommended by various authors. Dr. Giuseppe di Bella, in a report of cases treated in the clinics of Drs. Monteforte and Santi-Sirena, says that this agent has acted promptly and efficaciously in a large number of cases. Hebra has seen a number of cases of chancroid cicatrize in a very few days under treatment by salicylic acid. Dr. Ping y Falco has also obtained most satisfactory results with this same agent in similar cases. Dr. A. Farriols Anglada reports in the *Gaceta Médica Catalana* of October 15, 1886, thirty-two cases of soft chancre in which salicylic acid was used with the happiest results. This method, he says, possesses many advantages over the others hitherto used, and especially over the abortive plan. It is very simple, and the patient himself can carry it out; it is only necessary to wash the chancroid with some antiseptic fluid, and then to dust it with finely pulverized salicylic acid. In the great majority of cases, no more than two applications in the twenty-four hours are required, and in a few days (four or five, according to the author's experience) the ulcer loses entirely its specific characteristics. When this result has been obtained, that is, when the lesion has been converted into a simple ulcer, the applications of salicylic acid should be suspended, and a carbolic-acid lotion or boracic-acid ointment employed. Under this treatment, the ulcer becomes covered with healthy granulations, and cicatrization proceeds with great rapidity. Finally, Dr. Anglada urges, if we bear in mind that salicylic acid causes hardly any pain or inconvenience of any sort, in this way differing so greatly from the caustics ordinarily employed, we are forced to admit that it is a most valuable therapeutic agent in the management of soft chancres.

DOES A POSITIVE ABORTIVE TREATMENT OF SYPHILIS EXIST?

THE author of a memoir presented to the French Academy of Medicine at its meeting of November 9th, 1886, passes in review the cases of excision of the infecting chancre as practised by Diday, Langenback, Zeissl, Mauriac, Berkeley Hill, and some fifteen other observers, and out of one hundred and twenty-six cases collected finds one hundred and twenty-three failures and three reported successes.

A general review of four hundred and fifty-four cases gives one hundred and five successes and three hundred and thirty-nine failures. Among the cases, however, which passed for successes, there are few which can escape all suspicion that the diagnosis might be faulty, or that the cases might not have been followed for a sufficient length of time, or that erosions other than true chancres might have been operated upon.

When we consider how difficult it is, and even impossible often, two, three, or four days after the appearance of the chancre, to be positive of its nature, it is apparent how operation at so early a period may lead to error.

The author concludes that all attempts up to the present time to abort syphilis have been fruitless. The great majority of negative results is conclusive, while among the would-be successes some can only be accepted with the greatest caution and reserve, while the others are open to grave criticism. Therefore, the author puts down, as the best abortive treatment, the administration of mercury at the earliest date possible.

The author's name is withheld.

CIRCUMCISION AND TUBERCULOSIS.

DR. HOFMOKL communicated the following important case at a recent meeting of the Imperio-Royal Medical Society of Vienna: An infant of eight months had been circumcised eight days after birth; the hemorrhage being arrested by the rabbi, as is the custom, by applying his mouth to the wound. The child had been under treatment for six months before being presented to the Society. The wound from the operation did not heal, and six weeks afterward a slight ulceration of a grayish color on the corona and margin of the prepuce, together with swelling of the inguinal glands of both sides, were discovered. In spite of anti-syphilitic treatment and iodoform, the lesions extended and the glands enlarged and some began to suppurate. Dr. Hofmokl now extirpated thirty filbert-sized inguinal glands, under chloroform, finding some in a state of cheesy degeneration and some suppurating. The ulcer was superficially scarified with the thermo-cautery.

Tubercle bacilli were found in the glands, so that there remains no doubt that in this case we have to do with a tubercular affection. Bergmann reported at the last congress of surgeons in Berlin that he had observed a sort of epidemic of tuberculosis of the inguinal canal amongst Jewish children who had been circumcised according to the ritual, and had been convinced that the rabbi who had officiated had a tubercular ulcer on the tongue. It is, therefore, probable in this case that, as the mother and the nurse were healthy, the affection was caused by the circumcision.

THE ETIOLOGY AND THERAPY OF EPIDIDYMITIS.

DR. KRECKER (Dissertation, Breslau, 1896) gives a diligently prepared and very thorough dissertation upon epididymitis, its relation to gonorrhœa, and the various results of the disease which he has observed in the Breslau clinic, together with the means which have proven successful in the prevention of inflammation of the testicles in cases of gonorrhœa. Injections and washes of corrosive sublimate, 1 to 15,000, reduced inflammation of the epididymis from one case in five to one case in nine of those attacked with gonorrhœa, but was bound to be more irritating and less effective upon the gonococci than solutions of nitrate of silver varying in strength from 1 to 3 up to 1 to 2,000. It is especially important to continue the injections a long time, because the cocci have a way of appearing

again after all evidences of their presence have disappeared. This treatment is improved by the use of non-irritating five-per-cent solution of salicylate of sodium. During an average course of three weeks' treatment in this manner, only two instances of complications involving the epididymis were observed among a series of seventy-nine patients.—*Centrab. für Chirurg.*, No. 40, 1886.

TREATMENT OF HYDROCELE BY INCISION OF THE SAC AND EXCISION OF THE TUNICA VAGINALIS.

In the séance, of the 22d of October, of French Surgical Congress, Dr. Tédenat said: "The injection of iodine within the tunica vaginalis, as curative treatment of hydrocele, appeared to give ten per cent of relapses. It is true that they are less frequent if the pure, or almost pure, iodine is employed. The aseptic incision of the tunica vaginalis gives the best results, for relapses are much more rare. It has been said that no deaths occur from the iodine injections. While this is true, accidents, not without importance, have been observed, for instance, the penetration of the injected fluid outside of the tunica vaginalis, causing suppurative perivaginitis.

The absolutely aseptic incision does not produce any accidents, on condition that the asepsis is most vigorous, which is difficult to be assured of in this region. At all events, incision should be reserved for cases where the hydrocele is caused by a chronic epididymitis, where the tunica vaginalis is thickened, has calcified plaques, and is lined with false membrane. Injection should be reserved as the treatment for cases where there is well-marked transparency. It must not be forgotten that injections can be decidedly harmful when the cavity of the tunica vaginalis presents prolongations and diverticuli, reaching to the inguinal canal and even higher."

DIAGNOSIS AND TREATMENT OF TUMORS OF THE BLADDER.

DR. GUYON made some remarks at the October meeting of the French Surgical Congress upon tumors of the bladder, claiming that exploratory incisions are not requisite for diagnostic purposes, but that the symptoms presented, together with a clinical and anatomical examination, were sufficient in the majority of cases. He compared the hæmaturia symptomatic of vesical neoplasm with that of kidney tumor, in which latter the signs of renal ballotement and symptomatic varicocele aid us. He then dwelt upon the exploration of the bladder per rectum, per vaginam, and by catheterization, and said that little information could be obtained from the latter mode of examination.

A tumor of the bladder being discovered, it should be operated upon as soon as possible, unless all the walls of the organ are infiltrated with the disease. Malignant as well as benign tumors should be operated on, the fact being remembered that the malignant are almost always followed by a return of the disease, and that the benign usually get well. Benign tumors can occupy the bladder for a long time without causing the patient more annoyance than that caused by hæmaturia, etc. One should not hesitate to operate when in the presence of a complication such as cystitis, retention of urine, etc. The extirpation of the tumor, he believes, cannot be properly done except by the hypogastric incision.

INFLAMMATION OF THE SUBMUCOUS TISSUE OF THE GLANS AND PREPUCE.

At the meeting of the New York Surgical Society, held Nov. 8, 1886, Dr. Geo. A. Peters reported a very rare condition of the penis, for the relief of which he

had resorted to amputation of the organ, fearing that it might degenerate into epithelioma. The patient was sixty-five years of age, and the disease had begun about two years previously with pain in the penis, followed by changes which had rendered the glans and prepuce hard and unyielding. Pain, itching, and burning had been constant symptoms, and the patient had become almost hypochondriacal in consequence. Thirteen days after the operation, the patient was well. Microscopical sections showed inflammatory zones, and extending from them zones composed of small round cells (young cells) accumulated in places as in abscess formation, but without any tendency to break down. There was nothing to indicate carcinoma or sarcoma. Dr. Peters regarded the case as, in his experience, unique.

TREATMENT OF BLENNORRHAGIA.—According to the *Unao Medica* of October, 1886, Dr. Awssitidjiski records forty cases of blennorrhagia treated in the following manner:

During four or five days he prescribes for his patients a potion containing five grams of salicylate of soda in one hundred and eighty of the infusion of linseed. In case that the sensation of ardor urinae disappears, he orders injections of boric acid in two-per-cent solution to the number of from four to six a day for four days, ending finally with an injection of bichloride, 1 to 6,000, until the cure is complete.

Books and Journals Received.

Transactions of the American Dermatological Association at the Tenth Annual Meeting. Official report of the proceedings by the Secretary, DR. G. H. TILDEN. Boston, 1886.

Annual Address before the American Dermatological Association at the Tenth Annual Meeting, by the President, EDWARD WIGGLESWORTH, M.D.

Trophoneurosis of the Skin Caused by Injury to the Median Nerve, by G. H. TILDEN, M.D. Reprint.

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CORRECTION.

Page 7, line 11 from top, for: "by an influence so unpardonable" read: "by an influence so imponderable."

JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

VOL. V.

MARCH, 1887.

No. 3.

Original Communications.

PRACTICAL OBSERVATIONS ON THE GONOCOCCUS AND ROUX'S
METHOD OF CONFIRMING ITS IDENTITY.

BY

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DOES a micro-organism peculiar to gonorrhœa exist and can we recognize it with certainty in all cases?

Without dwelling upon the observations of Hallier in 1869, and of Salisbury in 1873, and the belief of others in the existence of a micro-organism or parasite of gonorrhœa, we will begin the retrospect of the history of the subject with the publication of Neisser (of Breslau), in 1879.¹ This eminent worker in the field of bacteriology found and described a micro-organism which he named the *gonococcus*. His observations have since been so thoroughly confirmed by such well-known investigators as Bokai, Bockhart and Wolf, Welanders, Sternberg, Keyser, Zeissl, Bumm, and many others, that it seems scarcely necessary to insist upon its existence. So little has, however, been written upon the subject in our own country that it seems justifiable to place on record the results of some personal observations. During the past three years, Dr. Wendt and myself have together examined the pus from all cases of gonorrhœa, purulent ophthalmia, and vaginal discharges, as well as a great variety of specimens of

¹ Centralblatt für die Med. Wissensch., No. 28, 1879.

pus from the pus-forming diseases which have come under our observation. We intend shortly to publish the results of our examinations in detail, giving such hints as to methods of staining and technique employed as may appear of value, and such conclusions as have been reached. At the present time I will pass at once to the conclusion reached by us in regard to the existence of the gonococcus, after an examination of over two hundred and fifty different specimens of discharge from the male and female genital organs. But first let me briefly recall the appearance of the organism as given by its discoverer. Neisser claimed that the gonococcus had distinct morphological characteristics, was at first round and then became somewhat oval, was comparatively large and seldom single, occurring usually in pairs, lying close together and forming groups, but never chains. At first he stated that he usually found these groups upon the surface of the pus-corpuscles, but more recently it has been discovered that they were really in the interior of the cells. The oval cocci divide by separating in their long diameter, forming a pair, or diplococci. These subsequently divide in their opposite diameter, thus forming a group of four, and so on until a pus cell is at times crowded with the organisms. When thus occurring in groups within the pus cells, they are considered pathognomonic.

In every case of acute or active gonorrhœa where the pus was taken directly from the urethra, it has been possible to find gonococci in their characteristic groups in the intra-cellular substance of the pus cells, usually in process of multiplying by fission, as well as in groups and as diplococci in the inter-cellular fluid, and to make an almost positive diagnosis from their discovery alone. In such cases, as a rule, no other bacteria are present. In many cases of gleet also, and such watery or mucous discharges as the clinical history would appear to show were of gonorrhœal origin, we have found gonococci sufficiently characteristic to confirm the diagnosis. Other bacteria are, however, usually present in this class of cases, and especially so in the gonorrhœa of women. Many of these organisms differ widely in appearance from the gonococcus, still some are so similar in form and size and even in their manner of multiplying by division and the formation of diplococci as to be mistaken readily for them. Early in our investigation of the subject we were forced to the conclusion that the morphological appearances of the cocci first described by Neisser as characteristic were not of themselves sufficient. In many cases of pus-forming disease in no way associated with gonorrhœa, micrococci were found having all the features of gonococci except that the groups were not in the pus cells, as they must be in gonorrhœal pus to be characteristic. In several instances such pseudo-gonococci, as Lomer has recently called them, were found in specimens of pus

from chancre, otitis media, carbuncle, balano-posthitis, etc. The importance of this is in the fact that true gonococci are found in groups outside of the pus cells as well as within them. Over two years ago, Dr. Wendt reported in the *N. Y. Medical Record* (Oct. 25th, 1884) that he had found cocci in the scrapings from various parts of the healthy male urethra, which so closely resembled Neisser's gonococci that from the size and form alone they could not be differentiated. The further our observations have extended the more have we become convinced that something besides morphological character is necessary to identify gonococci, and we have sought for some method by which they could be shown to differ from other organisms of similar appearance. By repeated examination of gonorrhœal pus one becomes so familiar with the ovoid formed cocci within the protoplasm of the pus cell, showing a constriction through one diameter, or having already separated are seen lying closely side by side, that he can make a diagnosis to his own satisfaction at a glance. When, however, these appearances fail and doubt exists, some confirmation of the microscopical appearances becomes necessary.

There are two ways in which the microscopical observation might be confirmed.

1. By making cultures of the micro-organisms and with them reproducing the disease by inoculation.
2. By finding some staining reaction applicable to gonococci and not to other bacteria.

As regards cultures, the difficulties surrounding the process and the indefinite nature of the results so far obtained from culture inoculations make this method impracticable for our present purposes. We will not discuss it further at this time.

In the following staining method, which was proposed by Dr. Gabriel Roux¹ at a meeting of the Paris *Académie des Sciences*, I think we have at last found a means of confirmation which the proposer is justified in regarding as "exact." His method is based on the fact that Gram's staining process is not applicable to gonorrhœal pus. Gram's method, as is well known, consists in coloring the dried specimen with methyl blue or gentian violet, then fixing the color on the micro-organisms with iodo-iodide of potassium liquid, next decolorizing with absolute alcohol.

After washing with distilled water, Roux then recolors with eosin. This procedure, which is applicable to other pus and secretions as before said, is not applicable to the pus of gonorrhœa, giving constantly negative results. Gram's liquid does not fix the color on the gonococcus, and when subjected to the action of alcohol the gonococci are decolorized at

¹ Le Concours Médical, Nov. 13, 1886.

the same time with the anatomical elements, and are scarcely recognizable under the microscope, while ordinary micrococci persist. Roux says it is, therefore, always possible in doubtful cases to determine the true nature of the cocci present by first staining with gentian violet, and after examining to treat with Gram's liquid and then with alcohol. If in a given specimen there is an absolute disappearance of the cocci which have been previously observed, they are surely those of Neisser. If, on the contrary, they persist and retain their violet color, there is reason to doubt the blennorrhagic nature of the affection from which the pus was derived. This method we have been able to confirm by repeated examinations of gonorrhœal pus from typical cases and have found it of great value in those of doubtful nature. We have examined pus containing a great variety of forms of bacteria, and find that, while the double coloration method brings out all other micro-organisms more beautifully than any other process we have employed, decolorization removes the staining from the gonococci and causes them to disappear, while other micro-organisms are not decolorized. Here, then, we have a method which, when carefully carried out, appears never to fail and has the great advantage of simplicity. The general practitioner can without loss of time examine a specimen for gonococci, and having found them, confirm his observation at once. I will briefly go over the process of rapid examination as practised by Doctor Wendt and myself. A drop of pus is spread into a thin layer by pressing between two glass slides, and allowed to dry in the air. A drop of a solution of methyl-blue in aniline water is now placed upon it for a moment and washed off with a stream from a wash bottle, a few drops of Gram's iodo-iodide liquid is then poured on and allowed to remain for several minutes. This fixes the color on micro-organisms in general. Gram's liquid is now washed off and while the specimen is still wet a cover glass is placed upon it and it is examined with an oil immersion lens. If micro-organisms resembling the gonococcus are found, we proceed to test them by decolorization. The cover-glass is removed and the specimen treated with absolute alcohol until the color is as completely removed as possible. The cover glass is replaced and the specimen again examined, when all gonococci will be found to have disappeared. All other organisms, however, which may have been present will be distinctly visible. If desirable, the pus cells may be brought out again by applying a solution of eosin. By this method we have been able to exclude all cases which would have been of necessity left doubtful without some confirming test.

In all cases of undoubted gonorrhœa, gonococci have been found and confirmed by this test whenever applied.

Groups of cocci from pus which was not gonorrhœal, although

resembling the gonococci, have been shown by their retention of staining to differ from them.

I think, therefore, it can be safely said there is no gonorrhœa without gonococci, and that although in some cases confirmatory tests are required, we have such a test at our command.

HAS THE DISCOVERY OF THE GONOCOCCUS ANY PRACTICAL VALUE?

The question of the significance of the gonococcus is indeed a most important one. By establishing the fact of its presence in the pus from the vagina we are enabled to make a positive diagnosis, while without its aid, as a rule, only the more severe and well-marked cases of gonorrhœa in the female and those having complications, or those in which the history of infection is perfect, are susceptible of positive diagnosis. The examination of vaginal secretions for gonococci is always unsatisfactory, and Lomer¹ regards their examination as of little value and unsuited for the detection of gonococci, believing they should be sought for in the cervical secretions. I believe, however, by the new test proposed by Roux we are enabled to distinguish gonococci from the numerous other micro-organisms usually found in vaginal discharge. Then again, as Schwarz has justly said, the uterus is at times found in a healthy state, presenting no cervical secretion available for the examination. The practical importance of the coccus is also seen in gleet and mucous discharges of long standing, as it is now well established that such chronic discharges, even of many years' duration, are capable of reproducing gonorrhœa. Again, it is often important to detect a latent gonorrhœa either in the male or female, and I have become convinced that the examination of secretions from the male urethra, which to the naked eye are apparently harmless, often show gonococci, and thus would be accounted for a resurrection of the disease after pure intercourse (that is, marital, or where the woman is proven to be free from disease), or after some local irritant.

In 1872, Noeggerath² stated that out of 1,000 married men in New York, at least 800 had had gonorrhœa, that 90 per cent of all gonorrhœa remained uncured, or at least became latent, but were still infectious in this stage, and consequently almost all women married to men who had suffered from gonorrhœa also became infected with the disease.

Schwarz³ thinks not over ten per cent to fifteen per cent of gonorrhœa cases in the large cities of Germany pass into the chronic or latent stage.

Neisser (German Medical Congress in Strassburg, 1886), has investi-

¹ Deutsche Med. Woch. Oct. 22, 1885.

² "Die latente Gonorrhoe im Weiblichen Geschlecht." Bonn, 1872.

³ "Die gonorrh. Infektion beim Weibe." Samml. Klin. Vortr., No. 279.

gated 143 cases of gonorrhœa which had existed for more than a year, with regard to their contagiousness. In more than half his cases, repeated injections of corrosive sublimate solutions had been employed, 1 to 20,000. Quadrate heaps of gonococci were found in the pus. He regarded such cases but slightly dangerous in occasional coitus, but certainly dangerous in marriage.

On January 28, 1886, the discharge of a gonorrhœa which I had been treating in the office by injection, since December 23d, ceased. On the 31st it began again after drinking wine and coffee, and gonococci which had almost disappeared were found again in great abundance, occurring as diplococci within the pus cells, thus showing the rapidity with which the organisms are called into activity by irritants.

Many times I have seen a gonorrhœa which had apparently passed into the chronic stage, or one that had almost completely disappeared or become latent, suddenly undergo an exacerbation, and gonococci which had existed only as scattered diplococci almost at once became very numerous and take on all the characteristics of an acute attack.

Schwarz says the more abundant the gonococci and the greater the vitality the more contagious is the pus in which they are found. If now this abundance and apparent vitality can be suddenly called forth by excesses in drink, coitus, activity, and mechanical irritation, is it not fair to suppose that a gleet or a latent gonorrhœa, which through coitus reproduces an acute exacerbation in the person affected, could also reproduce the disease in the female with whom coitus took place?

I have recently seen a case in which the patient stated that for the past sixteen years he had scarcely been free from attacks of gonorrhœa, the discharge beginning again each time he had connection. Evidently a latent gonorrhœa called into repeated activity. The discharge showed typical gonococci.

Furthermore, investigation doubtless proves that numerous cases of ophthalmia neonatorum showing typical gonococci are due to a vaginal discharge in the mother which had been regarded as a simple leucorrhœa, and those precautions neglected which would have been taken *ante partum* had the discharge been examined and gonococci found. I have thus traced by means of the gonococci a purulent ophthalmia in a child through the mother, who was innocent of her disease, to an infected husband. When we consider the vast number of severe and possibly fatal diseases of women, such as perimetritis, disturbances of menstruation, sterility, pyo-salpinx, peritonitis, etc., which are directly traceable to a previous gonorrhœa, the importance of early diagnosis and thorough treatment is apparent, leaving out of consideration the danger of infection to the male and to the offspring. Gynecologists are coming to recognize

more and more that many diseases of the uterine appendages are due to gonorrhœa, and the gonococci will be of no small aid in confirming such cases. Another extremely important rôle the gonococcus has to play will be found in medico-legal practice. A wife accuses her husband of having a gonorrhœa by which she becomes infected, suffers serious consequences, and sues for a divorce. Are gonococci present? Do they prove the case? A man is accused of rape, he is supposed to suffer from gonorrhœa. Do the secretions from the victim's vagina show the characteristic organisms of the disease? Many analogous cases will readily suggest themselves to the reader. A little girl was brought to me in February, 1886, having a yellow purulent discharge from an inflamed vagina. The question was raised whether some brute had not attempted to "cure" his gonorrhœa by contact with the virgin genitals, as occasionally happens in the extremely ignorant and depraved. The absence of gonococci enabled me to make a diagnosis of simple vulvo-vaginitis. But should the parasites be found, great care would have to be exercised, especially in a medico-legal case, and all possible sources of accidental infection would have to be excluded. Dr. Cseri reports that he has found cocci identical with gonococci in the vaginal secretions of twenty-six children in the hospital for children at Pesth. He thinks it is spread by washing, bath-tubs, dressings, water-closets, etc. In March, 1885, a man came to my office with an ulcerated condition of the meatus and interior of the urethra, discharging pus freely. An examination of the discharge showed diplococci such as are found elsewhere, but no typical groups of gonococci were present, and I excluded gonorrhœa. In cases of phimosis, where it is impossible to obtain a view of the meatus, and there is discharge of thick yellow pus, it becomes very desirable to know whether we have to deal with a gonorrhœa, chancre, chancroid, balanoposthitis, or some other condition.

In December last, I saw at Charity Hospital a patient in whom a urethral discharge had lasted for four weeks. He had been treated with Lafayette mixture without any benefit, the discharge remaining thick, and yellow, and having all the appearances of gonorrhœal pus. Examination showed an entire freedom from gonococci, and I reported that it was not gonorrhœa. The case turned out to be one of urethral chancre. I could cite other cases of doubtful diagnosis in which the presence or absence of gonococci made the diagnosis possible. The importance of the subject from a diagnostic standpoint is further shown in the examination of stains on linen, clothing, etc. On January 29, 1885, I was asked to give an opinion upon the nature of the stain upon a piece of linen brought to me. I soaked the spots in water, and prepared five specimens from the scrapings. All contained a variety of bacteria of

putrefaction. Two showed diplococci similar to those of Neisser, and three showed a few groups of gonococci, and I gave it as my opinion that the stains were those of gonorrhœal pus. Subsequent knowledge of the case proved this to be the fact. I have since experimented by staining linen with pus known to be gonorrhœal, and examining it in the same way from one to three weeks later, with the result of almost constantly finding gonococci within the pus cells, as well as diplococci outside, along with various bacteria. Gonorrhœal pus dried and kept for three years before examining, as well as stains on linen kept for the same time, gave only negative results.

IS THE GONOCOCCUS THE MATERIES MORBI OF GONORRHŒA ?

By most observers at the present day who are best competent to judge of the matter, the gonococcus is regarded as a specific microbe. Schwarz (*loc. cit.*) says the carrier of gonorrhœal contagion, or rather the contagion itself, is the gonococcus of Neisser. Welander¹ concludes from the examination of many cases that the gonococci are the pathogenic microbes of blennorrhagia. Bumm holds the same view, and the observations of such investigators have been quite generally accepted. This view would appear probable from the fact that the very same organisms exist in inflammatory conditions depending upon gonorrhœa, such as gonorrhœal ophthalmia, ophthalmia neonatorum, gonorrhœal joint disease, and diseases of the uterus and appendages, etc., and are not found in pus from other sources. The only way, however, in which the etiological function of the coccus can be proven is by the reproduction of the disease from an inoculation practised with a pure culture of the microbes.

So far inoculation experiments have not been highly satisfactory. Although a few workers in this field have succeeded in thus reproducing the disease, the great majority have failed. Bokai and Bockhart both report successfully inoculations of the male urethra with cultures, and Bumm² has reproduced a typical gonorrhœa in a woman by slowly introducing a culture of the third generation into her urethra. These observations have not been universally accepted as conclusive because of the manner in which the cultivations were made, the third and fourth generation of cultures not being deemed sufficient to positively exclude all other materies morbi.

Bumm's last successful inoculation appears, however, to have been done with all necessary precautions. In the second edition of his work on the micro-organisms of gonorrhœa (1887), Bumm records two observations

¹ Centralblatt für Chirurg., Nov. 22, 1884.

² "Der Micro-organismus der gon. Schleimhaut-Erkrank.," Wies., 1885.

which appear to show conclusively that pure cultures of the gonococcus are capable of exciting gonorrhœa. The first observation is that already given. In the second of his recorded cases, he used the twentieth generation of a pure culture in human blood serum and applied it to the mucous membrane of a healthy urethra in a woman, thus producing a typical gonorrhœal discharge, which began at the end of the second day. The pus showed characteristic gonococci. It was five weeks before the gonorrhœa thus caused was cured.

WHAT INFLUENCE HAS THE DISCOVERY OF THE GONOCOCCUS HAD
UPON TREATMENT?

Although the favorable results which might have been hoped for from bacteriotherapy cannot be said to have been fully realized, much benefit to therapeutics has come, I think, from the discovery of the gonococcus. Although the results so far obtained by those who advocate and use germicide treatment do not appear much superior to those following many of the older plans of treatment, still such complications as stricture, epididymitis, bubo, etc., would appear of late years to have diminished in frequency. The tendency nowadays is to carry out treatment in a more thorough manner, and to treat those cases which formerly were neglected, being regarded as non-virulent. Again in the matter of prophylaxis much is being done to prevent lying-in women from infecting their offspring, and by early treatment of the eyes of the newborn to guard against that destructive gonorrhœal form of purulent ophthalmia.

Haussmann (*Deutsche Med. Wochens.*, No. 25, 1885), following up the undoubted favorable results obtained by Credé's method of guarding against ophthalmia neonatorum, proposed the injection of a two-per-cent solution of nitrate of silver into the urethra immediately after impure intercourse. He says ten drops of the solution are sufficient to destroy the gonococci.

If we regard gonorrhœa as a parasitic disease, we would naturally seek our remedies among the parasitocides; the desideratum being to find some means of destroying the microbes without doing injury to the tissues. Many germicides have been recommended. Among them are to be mentioned more especially solutions of bichloride of mercury, ranging in strength from 1 to 500 to 1 to 20,000; permanganate of potash, in solutions ranging from a grain in every six or eight ounces to a grain to the ounce; solutions of quinine 1 part to 100. Solutions of carbolic, boracic, salicylic, and other antiseptic acids have been advocated. The bichloride solution is the one most generally employed at the present time.

To be efficacious, the use of a bichloride or other solution must be thorough and searching. Simple injections are not sufficient, as they do not carry the solution, as a rule, to all portions of the diseased urethra or female genital apparatus. Donches and irrigations made with heated solutions appear to give better results than when used cold. Undoubtedly the heat has a beneficial influence, especially in highly inflammatory conditions and where neighboring organs are implicated. In women, the cervix uteri and the upper portions of the vagina must be carefully treated by tampons soaked in the antiseptic solution, as advocated by Dr. Currier.¹ In the same way, a gonorrhœa which involves the deeper portions of the urethra is not reached by injections as usually practised. Prolonged deep irrigation from behind forward, or the use of Ultzmann's capillary catheter, or some similar instrument must be employed to carry the fluid to the desired spot.

I have recently seen a case in which, after three days' treatment with a bichloride solution, no gonococci could be found, although some pus still remained in the discharge, which was slight and watery.

I have treated gonorrhœal pus removed from the urethra with solutions of corrosive sublimate and peroxide of hydrogen, and upon staining and examining the specimens I have not been able to find that the gonococci were seriously affected to all appearances, much less destroyed. The peroxide of hydrogen solution destroys the pus cells, leaving the groups of contained gonococci unaltered.

Prof. Jaccoud, of Paris,² in closing a recent lecture on gonorrhœal infection, says the only antiparasitic agents, the utility of which has been established, are carbolized water and chloral, injections of one part to six hundred for the carbolic acid, and two to three hundred for the chloral; but all these measures need an internal treatment added as well, and this medication remains to-day what it has always been—that is, copaiba and cubebs. This view agrees in the main with the one I hold at the present time, regarding internal treatment. I expect, however, better results from anti-parasitic agents than we have so far obtained when methods of employing them shall be perfected. In the present state of our knowledge of the subject, I think the following conclusions are justifiable.

1. A micrococcus is found in gonorrhœa and gonorrhœal diseases which is not found elsewhere.
2. It is in all probability the specific microbe of gonorrhœa.
3. Its discovery has been of great practical value, especially as regards diagnosis and prophylaxis.

¹ N. Y. Med. Journ., Jan. 24, 1885.

² Medical Times Nov. 27, 1886.

4. The method proposed by Roux furnishes us the most convenient means of proving the identity of the gonococcus in doubtful cases.

5. As regards treatment, the discovery of the gonococcus cannot as yet be said to have produced any decided advances.

THE KENSINGTON, 102 East 57th St.

IS THERE A CHANCROIDAL VIRUS?¹

BY

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AS the title of my paper shows, I propose to question the generally accepted theory that the chancroid depends for its existence upon the presence of a virus—a theory which I think many syphilographers at the present day are almost ready to abandon, as they have already given up the theory of the gonorrhœal virus. I shall therefore divide my paper into the three following questions:

1. What is the virus of the chancroid?
2. Is not this virus really the result of an acute inflammation?
3. What are the sources of this virus?
1. *What is the virus of the chancroid?*

The term virus, when applied to venereal disease, and indeed to any disease, is purely a term of convenience to account for certain symptoms; it is the unknown quantity in medicine. We have not up to the present time been able to isolate the peculiar something which gives rise to the phenomena of syphilis, the various corpuscles and bacilli to the contrary notwithstanding, although the term as applied to syphilis is more appropriate than it is to the chancroid or to gonorrhœa, inasmuch as it produces a constitutional disturbance. The so-called virus of the other two diseases results in nothing but a local disorder and never becomes constitutional. I apologize for talking of the virus of gonorrhœa, but only do so because some authorities still speak of a virulent gonorrhœa. A virus, then, is something which poisons the constitution, and its symptoms are produced by this systemic alteration; if now we apply this test to the chancroid, we find it fails because the chancroid is a purely local lesion and it would be as sensible to talk of the virus of croton oil or of a pustule of scabies as of the virus of a chancroid. What, then, is the peculiarity of the chancroid which causes us to consider its existence as

¹ Read before the New York County Medical Society, February 28, 1887.

due to a poison? Its capacity for auto-inoculation; the power in it secretion for propagation. That is really what we mean when we speak of the "virus of the chancre." It is perhaps not necessary that that power should exist throughout the entire course of the disease, or else we should be under the obligation of denying the virus of syphilis, inasmuch as this disease is not inoculable during its entire course. In time we may come to that position, in fact it has been denied, but not as yet seriously.

But it will be of interest to note under what conditions, if any, the chancre is capable of being inoculated. If we turn to the records of inoculation, it is found to be during its acute stage, in other words, when the inflammation is highest; when that subsides it loses that power, but resumes it if the healing and harmless sore is irritated again into acute inflammation. Then it becomes capable of renewed auto-inoculation. I do not, therefore, think that we ought to consider this unknown power which produces only local manifestations as a virus.

2. *Is not this virus really the result of an acute inflammation?*

I have already called attention to the fact that the inoculation of the chancre exists during its acutely inflammatory stage and subsides when this condition subsides. Besides this, it can, when no longer inoculable, be made so by irritating the sore into virulence, when it again becomes "virulent." It is, then, possible to generate a chancre *de novo* without a fresh purulent infection occurring. These properties have, moreover, been believed to be peculiar to the chancreous pus and not to exist in any other kinds of pus, and this view has obtained much of its weight from the dictum of Ricord, who says that "I have inoculated upon the same patient, and that one hundred times, the pus of a chancre, the pus of balanoposthitis, the muco-pus of urethral blennorrhagia, the pus furnished by phlegmonous inflammations of other parts, and while the pus of the chancre invariably produced a chancre, the other kinds of pus remained of negative effect." Where chancre appears in the above extract, the word chancre should be substituted, for when Ricord wrote it he considered the simple venereal ulcer and the "initial lesion" as one and the same, grouping the two diseases under the generic name of chancre. But excellent as is the work which Ricord has done for venereal medicine, many of his deductions have been modified and even refuted by subsequent investigation and experiments.

In 1884-5, Pick, of Vienna, made experiments with pus taken from scabies, pemphigus, and acne pustules. These experiments were made upon syphilitic subjects and produced pustules which were auto-inoculable for several generations and did not resemble indurated chancres.

The next series of inoculations were made by Reder and Krause, also

in Vienna, with pus furnished by non-venereal affections. These inoculations were also positive through three generations, but they were also made upon syphilitic subjects.

Before going any further, let us note that the results were positive when simple pus, by that I mean pus derived from non-venereal sources, was inoculated upon syphilitic subjects. Was this due to the syphilis? The sores produced were not syphilitic. But we recognize the fact that the skin of syphilitic subjects is peculiarly irritable and prone to take on ulceration. Perhaps that is the explanation why these series of experiments were positive. But again another answer may be made that syphilitic subjects are depressed both physically and mentally and that this depression is the cause of the successful inoculation. We shall see by-and-by that this may be an important factor.

The next set of experiments were those made by Dr. Wigglesworth, of this country, while he was a resident in Vienna and were upon himself. He was entirely free from any constitutional disease and had never had syphilis. At the time of the experiment he was a little run down from overwork in the hospital. The matter taken was from an acne pustule on his own person and the inoculations were successful in several generations.

The next set of cases were recorded by Dr. Vidal, of Paris, who states that he had several times seen his "chef de service" inoculate the matter of ecthymatous pustules which were developed in the course of typhoid fever upon the patients who had furnished the pustules. "These pustules were frequently followed by the development of new pustules of ecthyma, identical with those from which the matter has been obtained.

These experiments were made as early as 1846. In 1852-3, he made further investigations during an epidemic of typhoid fever. He made inoculations upon two healthy men who had never had typhoid fever, with negative results. This is an important point to bear in mind. The rest of the experiments were made upon the bearers of the ecthyma from whom the pus was obtained, and in one-third of the cases he obtained positive results.

Finger's cases are the next in order as to time. They were reported at the meeting of naturalists and physicians at Strassburg, and are briefly as follows: A case came into his clinic suffering from vaginitis and eczema intertrigo. After the skin affection had disappeared, and after assuring himself that the vaginal discharge was not auto-inoculable, and that there were no chancroids on the genitals, he scraped off the mucous membrane from the vulvar posterior commissure, and keeping the parts in an uncleanly condition, he practised auto-inoculation with the slight purulent discharge which came from the erosion. This was unsuccessful.

He then powdered this erosion with savine powder, exciting abundant suppuration in the part. He then made two inoculations with this pus with success, producing ulcers which closely resembled chancroids. The erosion of the posterior commissure was then left alone and rapidly healed up. The pus from the two inoculations were then inoculated repeatedly, in all six times, upon the bearer of the original sore and upon a new subject. All were successful. Later on, in the original subject of these experiments, an inguinal bubo appeared, which softened and was opened.

Four more experiments were then made in the same manner as the one above described, and they were all successful. In one of them, an ulceration of the third generation, inoculated upon a man's arm, induced inflammation and suppuration of an axillary gland.

Here we have four sets of cases derived from various sources, and let us review them. In the first set (Pick, Reder and Kraus), simple pus is taken and inoculated upon persons who are the subjects of syphilis. These inoculations are positive through several generations, just as we find is the case in the chancre. It may be urged that the syphilis plays a part in producing the success; not directly, certainly; because the ulcers which were produced did not resemble syphilis, but were perfectly simple. Perhaps the syphilis induces a tendency to ulceration by producing irritability of the skin, but there its power stops. The second set (Wigglesworth) furnishes one case where there is no syphilis to invoke as the *deus ex machina*, and the result must stand upon the character of the pus furnished. This seems to have been sufficiently irritable, or shall we say sufficiently virulent, to produce ulcerations. The only other possible cause which can be assigned is a slight debility from overwork. The third set (Vidal) show that upon persons who are presumably non-syphilitic auto-inoculations occur when the experiments are made with ecthymatous pus, but it must be borne in mind that these persons are also debilitated. On healthy people the results are negative. Still that objection does not militate against the fact that simple pus is under some conditions capable of auto-inoculation. The same is true of the chancre; under certain conditions the pus is found capable of auto-inoculation.

In the last set (Finger), the inoculations seem to have been made upon persons who were and had been free from syphilis, and the pus used was laudable; and here again success attends the experiments. Not only were the results positive, and the resulting ulcers, to all outward appearances, as well as in inoculability, chancroids, but in two cases suppurative buboes occur. The results could not have been more brilliant had the pus taken been chancroidal instead of simple. If then this condition of

things obtains that simple pus and chancroidal pus are both capable of auto-inoculation, they must be due to the same cause, on the principle that two things which produce the same result are due to the same cause. But we are hardly ready as yet to talk of the virus of scabies or of acne or of ecthyma, then why talk of the virus of the chancroid? Is it not simpler and more scientific to drop the term, or else, if we must from force of habit continue the name, to remember that it is a term of convenience, designed to cover scientific ignorance. I believe the adoption of this view is only a question of time, and that we shall formulate our ideas of this interesting subject in the words of one of our writers—now, alas, no more—namely, that “the chancroid does not depend upon a specific virus of its own, incapable of being generated *de novo*. If the view here advocated be the correct one, it suggests an interesting analogy with the history of our belief as regards the nature of gonorrhœa, an affection which in the last century was regarded as due to the syphilitic virus. Ricord finally adduced convincing proof that it had nothing to do with syphilis. It was afterwards supposed to depend upon a virus of its own, the gonorrhœal virus. We now know that it may be caused by any simple irritant, but more especially by the pus from the urethral and other inflamed mucous membranes, whether originating or not in contagion. Such as the history of gonorrhœa has been, so we predict the history of the chancroid will be.”

3. *The sources of this virus.*—The principal source is at the present day believed to be from the secretion of a chancroid, and such is undoubtedly the case; but only a certain portion of the secretion, viz., the pus corpuscles, as witness the experiments of Rollet. This observer filtered the secretion of a chancroid, freeing it of its pus-corpuscles, and the resulting filtrate upon inoculation proved to be innocuous. Hence the so-called virulent property of this lesion depends upon the products of inflammation, pus, and not upon the other fluid constituents of the secretion. But is there no other source of the disease?

It has been suggested that the secretion of some of the lesions of syphilis might be the cause of chancroids under certain conditions, but text-books are, for the most part, silent upon this point. Instances have occurred, however, in which it would seem as though this view was supported by facts, and not by theory only. Clerc and Robert inoculated through several generations matter taken from syphilitic sores, making the experiments upon the bearers of the lesions, and these inoculations were successful. Clerc formulated his belief that chancroids were the result of the inoculation of the matter of an indurated chancre upon a person who either is suffering or has suffered from constitutional syphilis. He it is who gave the name to the sore.

In 1854, M. Maratray (de Nevers) published the case of one of his friends, who, during an attack of syphilis, contracted during impure coitus a lesion which upon examination proved to be a phagedenic chancre. Another man had connection with the same woman upon the same day as M. Maratray's friend. He, upon examination, was found to be the unhappy possessor of an initial lesion with the characteristic inguinal adenitis, and subsequent symptoms appeared as confirmatory of the diagnosis. The woman, who was the cause of the trouble, was also examined, and an initial lesion was found on her, and later she likewise showed symptoms of constitutional infection.

Ricord, in 1856, gives two cases. The first concerned an old patient who had been treated eighteen years previously for syphilis. He had not slept with a woman for two months prior to the infecting coitus. He was also apparently well of his syphilis. The coitus was followed in a few days by two chancroids which Ricord treated locally with happy results. The feminine cause of this disturbance was hunted up, examined, and found to be suffering from "a typical indurated chancre of the labium majus, with an enormous chancreoid induration." Subsequent syphilitic manifestations confirmed the diagnosis.

The second case is that of a girl who was infected with syphilis in June, 1856. During the last part of that month, a former patient of Ricord, whom he had treated in 1842 (fourteen years previously) for syphilis, had connection with this girl, and this unlucky encounter resulted for the man in a couple of chancroids which were treated locally and were not followed by any constitutional symptoms.

These three cases would seem to bear out M. Clere's idea that the chancreoid is the inflammatory expression of an initial lesion, occurring as they all did upon persons who were or had been under the influence of syphilis. But it may be said that these sores were not chancroids at all, but simply initial lesions, devoid of induration and not followed by subsequent manifestations because the patients were already under the diathesis and therefore protected. Perhaps; but what shall we say to the next case which is that of M. Rey? Two men, A and B, free from past or present syphilis, have connection on the same day with the same woman, C. A has an initial lesion and inguinal adenitis, B has four chancroids. C is examined and is found with an initial lesion. The sequel is as follows: A has cervical adenitis and mucous patches in the mouth, B has a suppurating bubo without any constitutional symptoms, and C has a macular syphilide.

Now how to explain this apparent anomaly. A contracts what we should expect he would, syphilis, but why should B have chancroids only? Because A by his coitus has excited C's initial lesion into suppura-

tion, and B, who has follows A in coitu, luckily gets off with chancroids instead of syphilis. An ingenious explanation perhaps; but is it a correct solution of the problem; are there any other cases which will bear out this theory? Remember there is no syphilis here to account in B's case for a chancroid being derived from an initial lesion, so Clerc's theory will not suffice; we must find cases of persons free from syphilis in whom chancroids have been derived from syphilitic lesions.

Bidenkap and Gjor, of Christiania, give between them four cases. (One of Bidenkap's cases I omit, as it might be open to question.) They are as follows:

M. enters Bidenkap's ward suffering from vaginitis and urethritis. She had never had any previous venereal disease. She inoculated herself with the secretion of a chancroid. This sore was the result of inoculation through several generations from the secretion of an initial lesion, made for the purpose of syphilization. This experiment resulted in a sore to all appearances a chancroid, which was accidentally auto-inoculated with success. It finally healed up without any manifestations of syphilis supervening, although the patient was kept under observation for some time. A year and a half after, she returned to the hospital with an initial lesion which was followed two months later by a macular syphilis.

Gjor's first case is that of F. who inoculated herself with the matter derived from the secretion of mucous patches which had been auto-inoculated. The auto-inoculation was successful and she never showed any sign of syphilis.

The second case, H., inoculated herself in the same manner as the above patient, with the same result. Kept under inspection for five months, she showed no signs of syphilis, but two years later she contracted an initial lesion followed by the usual manifestation of syphilis.

The third case, S., was similar to the other two cases and presented the same symptoms; successful inoculation without constitutional manifestations.

Here then are four cases of persons free from syphilis past or present. Matter derived from the secretion of an initial lesion and from mucous patches is successfully inoculated, producing sores which to all intents and purposes are chancroids. That they are simple sores and that they have not infected the constitution is very evident in certainly two of the cases, because in them syphilis occurs later on, as a fresh infection.

With these facts in our possession, what answer shall be given to my three questions? I myself should reply as follows:

1. What is the virus of the chancroid? There is none.
2. Is not this virus really the result of an acute inflammation? I believe it is.

3. What are the sources of this virus ?

a. Chancroidal pus.

b. The secretion of the initial lesion of syphilis and of mucous patches, provided the secretion of these lesions is irritated into purulence. The resulting pus then gives rise to a local sore resembling a chancre in external appearances, capable of auto-inoculation in several generations, when transferred to a sound person giving rise to a similar local sore and not infecting the constitution.

16 WEST 32D STREET, New York City.

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THE CUTANEOUS PUNCH.¹

BY

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IN the summer of 1879, a young gentleman, living as a neighbor in the country, while discharging some piece of fireworks, blew his face full of specks of partly burnt powder. I was called by the father to remove this disfigurement, which was very considerable. I attempted, while the wounds were yet fresh, by scraping and gouging with various instruments, and washing away the more superficial specks to remove the cause of trouble, but with very imperfect success. A number of sittings were held; the patient constantly becom-

¹ Read before the New York Dermatological Society, January 26, 1887.

ing more restive and dissatisfied; although the intensity of color in most of the places could be diminished by the methods I employed, yet the healing of the little specks left the cicatrix of a blue tint, which in few, if any, of the affected areas could be entirely removed. One of these sittings took place under an anæsthetic.

Finding at last, when the little wounds had all healed, that my patient was marked in an unseemly manner, I determined to eradicate the numerous points of disfigurement, by entirely taking away the portion of integument involved in the colored scar. To do this I devised a number of small cutaneous trephines, or punches, as they may be called, with a sharp cutting edge; the diameter of the cutting edge varying from one millimetre upwards, each larger trephine having a diameter one-half a millimetre greater than the one next below it.

These little instruments, by being placed upon the skin and sharply rotated, would cut out a circular piece of integument of the size corresponding to their own lumen, and the depth of the excised portion could be varied according to pressure.

Under ether, in two sittings, with these instruments, I removed several hundred colored specks from the face of this young gentleman.



The color, in some instances, penetrated all the layers of the true skin, and even involved the muscular tissue beneath. In a number of places upon the ear, the cartilage had to be cut through, and removed by the revolving disc, as it contained the pigment. The smallest sized punch which could cover any given pigmented area was, of course, used to remove that particular blemish. The bleeding was exceedingly moderate. There was no difficulty in penetrating the tissue of the eyelid, or the lip. After the colored spot had been surrounded by the circular incision made by the punch, and showed slightly above the surface, being seized by a pair of fine toothed forceps, it was slightly pulled upon, and snipped away with a pair of small scissors curved upon the flat.

The result of this trifling operation was admirable. The little bloody pits in the skin were allowed to fill with coagulated blood, and left without any dressing, as the bleeding promptly ceased. One year after the operation, no casual observer could notice that anything had been done to the face of this young man. The scars were practically invisible.

My next case upon which I tested this instrument was one of a charming old lady, suffering seriously from gout. Her feet were tender

because of this malady, and her locomotion seriously impeded. Added to her tortures were a series of ordinary corns, soft and hard, for which she sought the aid of a chiropodist at repeated intervals, but with unsatisfactory result, since she was hyperesthetic and doubtless did not allow him to manipulate satisfactorily. She therefore sought my aid, and it occurred to me that this instrument was a suitable one with which to do away with the central tender portions of each of her enemies. I therefore administered ether, having some larger punches made, and applying them rapidly to some half dozen or more corns, soft and hard, upon the outer side of the foot, and between the toes, I promptly took away the central portion of each, including the entire thickness of the true skin. Each little cavity was filled with dry powdered subsulphate of iron, and allowed to dry down, the dressing being thus composed of an iron scab. Some of the opened out places healed under the scab without suppuration, several of them suppurated slightly, but all got well promptly, and the old lady, from that time onward, enjoyed an unaccustomed use of her feet. *

Shortly after this, another patient appeared with an epithelioma upon the forearm, a short quarter of an inch in diameter. This was rapidly removed, the loss of tissue being filled in, in this instance, with powdered salicylic acid, and an antiseptic dressing applied. The result was admirable, with a small central puckered scar.

Next in order, I tested this instrument upon several cases of commencing rodent ulcer, at the side of the nose, and upon the lower eyelid. Here the application of the trephines was very exact, in limiting precisely the amount of tissue which it was desired to take away. Much neatness and dispatch were obtained in this operation, which in this particular position is sometimes annoying in its performance, on account of the amount of hemorrhage which it is customary to encounter here.

I have also used the instrument to take away from the face of young ladies, and fastidious young gentlemen, small moles and other disfigurements. I have found it possible in some instances, by carefully circumscribing the pigmented area, to cut away the colored deposit through the continuity of the true skin, without destroying the entire thickness of the felted sub-papillary layer beneath, in this way removing the discoloration with a minimum of the resulting scar. I think that these uses, and a number of other similar ones which readily suggest themselves, are sufficient to commend this little instrument for general adoption among dermatologists.

There is no limit beyond which the size of the cutting circle may not be increased. In removing any tumor which involves only the thickness of the true skin, it is simpler and more expeditious first to punch it out in

this manner, and then, if necessary, with scissors curved on the flat, to convert the circle into an oval incision.

In this way, the tumor may be more promptly removed than by any other method with which I am familiar, and with less hemorrhage, more accuracy in the curve of the incisions, greater thoroughness, and a more easily adjustable symmetrical edge, on each side, to be drawn together by stitches if they are to be employed. Thus far I have never used a punch larger than ten millimetres in diameter.

Doubtless, instruments of this kind had been used before I employed them; I had not ever seen them described, however, and their use is certainly not yet generally known, for the few gentlemen to whom I have shown my instruments have been unfamiliar with them, or with the idea involved. I have used them constantly since 1879. In 1884 there appeared in the *Berl. Klin. Wochenschrift*, XXI., from the pen of Dr. F. Busch, an article advocating the use of what he calls a quickly rotating punch, for the extirpation of small round tumors of the skin. He advises that such a punch be attached to a dentist's drilling engine, or the Horteloup's artificial leech. He thinks that the punches are best adapted to small tumors, of one centimetre in diameter or less. The idea here is identical with the one I have just described; and it is quite possible that other similar descriptions of instruments may exist in medical literature which I have not observed.

The dressing of the minute wounds left by the use of this instrument may depend upon the wish of the surgeon. I generally employ nothing for the smallest punctures; dry powdered subsulphate of iron for the larger ones, when they bleed freely; bismuth, iodol, and iodoform in certain selected cases.

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PSORIASIS.

DR. HAUMER (*Deutsch. Med. Zeit.*, September 20, 1866), draws the following conclusions from his observations of a large number of cases:

1. In one-half the male patients, the knees were found entirely free; in the female, almost never free.
2. Hereditary influence is frequently noticed; father and daughter, for instance, being affected and in hospital at the same time.
3. Only microbes of normal skin (the microphytes described by Bizzozero) were found, and attempts at inoculation failed.
4. The application of chrysarobin in chloroform (1 to 10) was found to be the most successful treatment.

MALIGNANT DEGENERATION OF MOLES AND OTHER TUMORS.

BY

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I PERUSED with much pleasure Dr. Sherwell's article, "Remarks on, and Queries as to the Relative Frequency of Pathological Changes in Moles and other Tumors on Face and Head," having given this subject much attention for some time.

That moles, etc., often undergo malignant degeneration I have not the least doubt, having witnessed it time and again in the form of both the epitheliomatous and sarcomatous. Reference here is made only to such cases perfectly clear, both as to history and microscopical confirmation of diagnosed malignancy. These have for the most part been found on the face, but also occasionally on other parts of the body, where the growths were subjected to continual mechanical irritation. I think that this last factor is the real exciting cause, atmospheric changes and exposure to them having very little or nothing to do with it, as Dr. Sherwell's observations on *nævi*, etc., plainly show.

Dr. Sherwell's quadrangle is well mapped out, and the greater frequency of malignant degeneration in moles and other tumors in this region is because of their greater exposure to irritation here, as well as the abundance of circulatory nutrition. The presence of these little growths here among ladies affected with them, and they may be seen almost constantly picking at them; again in men they are frequently cut into during the process of shaving, and after a time present an ominous look. These changes I have also noticed when a mole on the back of the neck was continually irritated and torn by a collar button, and below the knee, due to the pressure of a garter (the case below the knee, referred to here, proved to be a sarcoma developed from a congenital mole; it was removed by the knife twice, recurring each time, when a final good result was obtained by electrolysis, my favorite operation). My conviction that moles and other growths degenerate malignantly when subject to irritation is so strong that I always propose their removal to my patients, when situated in such region as to be favorable to mechanical irritation. The more active circulation in the face, together with its more exposed condition, may be urged to explain the more frequent malignant degeneration of the growths in question in this region, but it will take place in regions with a much smaller blood supply, provided a sufficient amount of irritation is brought to bear. Possibly there may be

another factor worth noticing, and that is predisposition, and should there be a cancerous history connected with any one having moles, these growths would seem to call for immediate removal without waiting for any evidence of commencing pathological changes.

In connection with the above, I beg leave to communicate the following from the pen of Dr. V. Biart, U. S. A., and which is worthy the closest consideration:

“In regard to malignant degeneracy, I think I have noticed that, apart from irritation (which is in many cases an *essential* factor), there is generally a condition of general failure (system below par), that is, a lowering of tone, as instanced by debility, illness, drains on the system, lactation, etc., in or beyond the middle age, for instance, when the renewal of the tissues is not always adequate to compensate their loss by the phenomena of life, cancers are most frequent. That is to say, normally we have necrobiosis; in the growing animal, more biosis than necrosis (if I may be permitted to say so); at maturity in standard health, the processes of decay and nutrition balanced; and in loss of health and tone, more necrosis than biosis, more decay than regeneration; and I think the latter condition has much to do with malignant degeneration. Depression of the nervous system, by interfering with the trophic functions in the human economy, is another element in the case.”

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

169TH REGULAR MEETING.

DR. ROBT. W. TAYLOR, *President, in the Chair.*

DR. ROBINSON presented a

CASE OF PAPILLOMATA,

in which the lesions occurred upon the cheeks of a German lady aged 50.

He desired the opinion of the society in regard to the frequency of its peculiar, white appearance. The disease has existed for ten years upon the left cheek, and two years ago a similar growth appeared on the right side. The patient says it began upon the seat of an ordinary mole, such as she now has upon the chin. The growths are covered with hard, heaped up crusts of epithelial cells, which she is in the habit of removing with her finger nail. The growth on the left cheek has attained a diameter of one-third of an inch, and that on the right is about half this size. Around the base of the tumors are found small white nodules which appear to be collections of sebaceous matter, having a thin covering of epithelium. When scraped out, the contents of these nodules are found to be quite

similar to that of sebaceous material, viz., fat and epithelial cells. The central portion of the growth appears warty, is of firm consistence, and bleeds readily upon scraping.

DR. SHERWELL thought that the growths, were likely to take on epitheliomatous changes.

DR. FOX would expect cutaneous horns to form upon the growth if the accumulation of epithelial cells were not interfered with. He recalled two cases which had occurred near the angle of the eye, in which a circular ring, resembling that about the base of the growths in this case, was present and on which horns developed. This soft papillomatous condition is found beneath the horn when it is pulled off.

DR. MORROW could not agree with this view, as the growth seemed to be distinctly papillomatous and like an ordinary wart. In cornu cutaneum, the envelope was continuous with the skin without any break. He would expect the disease to develop into a malignant growth. Hard sebaceous concretions are found in epitheliomatous development.

DR. KEYES considered it a papillomatous warty growth containing more or less sebaceous matter, and that the chances were in favor of its becoming epithelioma.

DR. ALLEN regarded it as papilloma and would advise thorough removal to avoid the chances of epitheliomatous development.

DR. TAYLOR agreed with Dr. Fox in a measure. This region was the one in which cornu cutaneum was prone to occur. They begin as hard warts and the epithelial horny elements increase rapidly. Any epithelial growth in an elderly person is prone to take on an epitheliomatous development. The length of time the disease had existed would point, however, to a benign growth, for having existed ten years without showing changes would favor its non-malignancy, and he would regard it as commencing cornu cutaneum.

DR. KEYES had never seen horns so white as the masses of epithelial scales were in this case.

DR. BRONSON said that Unna had shown that in horns of the skin the usual dark coloration existed throughout the whole thickness of the horn.

DR. FOX said that the cutaneous horns could develop into epithelioma. In his atlas of colored plates, a cutaneous horn is shown upon the lip of a patient of Dr. French, of Indianapolis, alongside of which is a large epithelioma. He referred also to another similar case which he had observed. He thought there were chances of these tumors becoming epithelioma, but that it was hardly probable, as they had existed so long.

DR. ROBINSON had seen the case but a few minutes before presenting it as one of papilloma, and thought it of interest on account of the peculiar whitish pearls or collections of matter about the margin. If the patient's statement was to be taken that the tumors had sprung from ordinary moles, this fact would favor the diagnosis he had made, as against that of cutaneous horn. He had no objections to the view that epithelioma would likely develop and he would indeed favor it, as the growths had commenced to change late in life from ordinary mole into papilloma.

DR. KEYES then read the paper of the evening on

THE CUTANEOUS PUNCH,¹

and showed instruments of a variety of sizes, to which he had given the above name.

In the discussion, DR. BRONSON considered the instrument a decided addition to our armamentarium.

DR. SHERWELL thought it admirably adapted for the removal of moles and similar growths, but the difficulty would be that the general practitioner would be forced to keep too large a variety of the punches on hand.

DR. ROBINSON suggested that the cutting could be better done if the parts were frozen with ether.

¹ See page 98.

DR. JACKSON had seen the results of the application of the instrument which had been very favorable. He had recently seen a case of rodent ulcer upon which Dr. Keyes had operated three years ago which had remained cured.

DR. FOX thought its use in small rodent ulcers would be admirable, but doubted its being as good a method in the removal of powder spots as the electrolytic needle with a current strong enough to produce suppuration, thus destroying the pigment deposit in the skin. For this purpose, ten or fifteen cells are often necessary. Small punctate cicatrices result, which in time become scarcely noticeable. He had found electrolysis to be a very satisfactory method of removing powder stains from the face, but in his next case would try the method suggested by Dr. Keyes and compare the results. His experience in the use of ether as a local anæsthetic had not been favorable, the actual freezing being difficult and the use of ether appearing to him to be often of more trouble and little value.

DR. ROBINSON answered that if the skin be slightly scratched or irritated first, it then can be readily frozen, but that without such slight lesion the freezing process was difficult. In his hands, ether-freezing acted well and operations could be done without patients feeling pain.

DR. MORROW regarded the instrument as ingenious and well adapted for the removal of distinctly circumscribed tumors, but he doubted if the operation would succeed as well as incision, with scraping, in lupus or malignant tumors where the growth was diffuse, with peripheral proliferation.

DR. TAYLOR thought Dr. Keyes had made an important addition to the surgeon's armamentarium, especially for the removal of xanthoma and similar tumors about the eye, and for the deeper hypertrophies.

In closing the discussion, DR. KEYES said the resulting scar was usually small. As an after dressing he used largely the dried subsulphate of iron. He had devised the instrument for the removal of a severe case of powder spots in the face, and at that time did not know that electrolysis had been used for the purpose. In oval incisions, the cuts were apt not to be symmetrical. He operated without freezing or the use of cocaine, and by putting the skin tightly on the stretch, had found that little pain was complained of, as the incision was so quickly made. The part incised juts out and is easily cut off with flat scissors.

DR. JACKSON presented photographs of a case which he had expected to show to the society, which illustrated in an admirable manner the condition of

KELOIDAL SCARS FOLLOWING ZOSTER.

DR. SHERWELL asked what was the opinion of the members present in regard to the nature of the keloidal growths which come upon the site of a vaccination and tend to disappear spontaneously. He had treated them by painting on contractile collodion, which seemed to do good.

DR. BRONSON said they came under what Kaposi had described as hypertrophische narbe or false keloid. It differs from true keloid in not advancing into the neighboring sound skin, and is usually associated with some traumatism. He had seen them follow other conditions besides vaccination.

DR. KEYES had recently seen some rounded keloidal growths in the neighborhood of a vaccination which were of a pink color and disappeared in a few weeks.

DR. MORROW stated that a large number of cases of the so-called "raspberry tumor" had come under his observation. They usually occur as phenomena of revaccination, being rarely observed after primary vaccination. The clinical characters of these pigmented neoplasms, their relation to true vaccination, and their prophylactic significance he had discussed several years ago in an article on the "Incidental Effects of Vaccination." These red tubercles he regarded as essentially different from keloid. They are soft, elastic, of a reddish apple-jelly hue, and highly vascular. They are also intensely itchy, and, usually, after a variable interval of from two to six months they disappear spontaneously. He had seen two cases in which the involution was much slower, as the tumors had existed in one case two, and in the other four years. They are usually formed by the coalescence of small papules, or they may develop from a single papule. They rarely attain to larger dimensions than a large pea or hazel-nut, and do not,

as a rule, spread beyond the area of surface involved in the incision or scraping. So far as he knew, no microscopic examination of these raspberry tumors had been made for the purpose of determining their histological characters.

DR. ALLEN said a man had recently applied to him for the removal of a keloidal growth following vaccination on account of the annoyance and irritation produced by it. He had preserved the specimen and would examine it with the microscope. He had seen such a growth as that mentioned by Dr. Keyes develop over an inch distant from a vaccine mark and persist for about two years.

DR. TAYLOR had once presented to the Society a hospital patient with a keloid following syphilitic cicatrices, the result of a rupial syphilide, and had secured a beautifully-colored photograph of the disease. The patient had recently returned to the hospital and all the hyperæmic keloidal scars had subsided, leaving white, glistening, and depressed scars in their place. The strawberry and raspberry-colored growths following vaccination he regarded as dependent upon hyperæmia and inflammatory changes, with an increase of the fibrous tissue and capillaries. By the contraction of the fibrous tissue upon the capillaries, the flat scar is produced.

He had expected to present to the Society a patient who had failed to arrive. She was a female, aged sixty-four, who had upon the chest, in the region in which keloid so commonly appears, a pendulous tumor resembling in size and appearance a scrotum filled with varicose veins. After excluding all other conditions, the diagnosis was made of fibroid developed after a kick. Over the region of the spinous process of the axis were found two fibrous mollusc growths, also believed to have followed traumatism. It does not of necessity follow that one gets a keloidal growth from traumatism, but a diffuse fibrous growth of the skin.

DR. ROBINSON asked why the diagnosis molluscum fibrosum was made in the case presented in November, if there was only a diffuse patch.

DR. TAYLOR said that there were developed in the patch fibrous molluscs corresponding to the marks of the teeth.

DR. ROBINSON said that false keloids were more frequent after abortive vaccination than vaccination which "took;" as to their duration, he had seen them last for years. They were of the nature of hypertrophic scars and he did not regard them as infrequent.

DR. FOX thought the use of the term keloid should be restricted to apply only to the unmistakable cases of the disease having the well-known features of peculiar color, tenderness, and a tendency for processes to jut out into the sound skin from the mass of the tumor.

FIBROMA OF LOBULE OF EAR.

DR. KEYES asked if there existed any better treatment than cutting for the fibromata which grew in the lobule of the ear after piercing for ear rings. It was the general opinion that operation with the knife was called for. Dr. Fox spoke of the electrolytic needles for this condition. Dr. Keyes said he now had a case which had been operated upon six times and each time the growth had returned worse than ever.

DR. FOX showed in an instrument for

LOCAL MASSAGE OF THE SKIN

which he had found useful in thick doughy infiltrations of the skin and in acne, where it was difficult to empty the cutaneous glands of sebum, etc.

PYO-SALPINX OF GONORRHOEAL ORIGIN.—Dr. Price exhibited at the December meeting of the *Obstet. Soc. of Phila.* specimens from a case of pyo-salpinx of gonorrhoeal origin, and asked if this disease was not generally, or indeed always, the result of gonorrhœa. In his experience, the cases have without exception, followed attacks of gonorrhœa.

Correspondence.

DERMATOLOGY AND KINDRED STUDIES IN GERMANY.

The Treatment of Spermatorrhœa.

DR. GRÜNFELD, of Vienna, in an article appearing in the Nov. and Dec. numbers of the *Centralblatt für die gesam. Therapie*, says the treatment of spermatorrhœa must be at the same time general and local. The local treatment having reference to the uro-genital tract, and the general, to the nervous disturbances and the diathetic conditions present. The local treatment will be principally instrumental. But it must be distinctly understood that every case of spermatorrhœa is not unconditionally to undergo treatment with instruments. Occasionally a cure is brought about simply through regulation of the diet and sexual relations. Instrumental treatment may be either mechanical or chemical. A single method cannot be applicable to all cases of this kind.

The mechanical treatment consists principally in the so-called sound cure. Metallic sounds are introduced into the urethra as far as the neck of the bladder and left quietly in place for from five to fifteen minutes. This is repeated daily or every second day, and the size of the sound is gradually increased, beginning with a sound of small calibre. The largest sizes may be dispensed with. The effect of the sound cure is plainly a mechanical one alone, and we can understand how through the systematic introduction of the instrument, we finally may blunt the sensibility of the extremely sensitive portion of the urethra. Individuals who, in the beginning of the cure, are thrown into a state of excitement and experience severe pain by the mere contact of the sound with the genitals, later on bear the introduction of the instrument exceedingly well. Aside from the blunting of the sensitive part of the canal, the introduction and especially the retention of the sound has the effect of diminishing the swelling of the parts by compression. Indeed it is possible that the intense irritation is not without its effect upon the previously relaxed muscles of the organ. In hypertrophic enlargement of the prostatic portion of the urethra, this method should be advised against if the pressure upon the urethral walls is pronounced. The application of the cold sound is suitable for some cases, but one first warmed in lukewarm water is far better borne, especially by sensitive persons. Elastic sounds are, for this purpose, scarcely admissible.

More important than the mechanical is the chemical treatment, especially the local application of astringent or caustic substances in the neighborhood of the prostatic portion.

Lallemand showed that involuntary loss of semen, pollutions, etc., were not due to cerebral, nervous, or other like affections, but that we had to deal with an affection of the prostatic portion of the urethra which could be cured by methodical cautery of the part. With the aid of the endoscope the diseased portion can be clearly seen, and not only astringent, but also caustic applications be made to the desired spot. The endoscopic cautery of the colliculus seminalis (other areas of the prostatic portion are not taken into consideration) can be carried out in several ways. First of all, the nitrate of silver stick can be used, and only a portion

of the endoscopic field burned, or several fields in succession, according to the nature of the case and the individual. If the whole field is to be cauterized, powdered nitrate of silver can be applied on a cotton tampon. Neutralization with a salt solution can usually be dispensed with, as the pain is slight.

The author favors especially an alcoholic solution of corrosive sublimate in strength of one-fourth per cent to one per cent, which has the advantage over the nitrate of silver of causing a deeper effect, and is more useful when bacteria are found in the urine. The tincture of iodine is a valuable agent, acting rather as an astringent than as a caustic. Its use appears chiefly valuable in cases where the sub-mucous tissues are thickened. The use of Ultzmann's urethral injector is praised as an easy means of applying from one to five drops of a five or ten per cent nitrate of silver solution to the prostatic portion. The point of the catheter must come precisely in the middle of the prostatic portion before the injection is made. Dittel's instrument for treating the urethra by suppositories is also well spoken of. As regards general treatment, the digestive functions must be carefully regulated, and no constipation or diarrhoea allowed to exist. Beer and wine are recommended in small quantities.

In pale, anæmic patients, iron preparations, quinine, exercise in the open air, cold or lukewarm baths, etc., are to be employed.

The use of cold sitz-baths, especially at night, are useless if not injurious. On the other hand, a mild course of hydrotheraphy is often advisable. The morale must be carefully looked after, the patient encouraged to look upon his affection as insignificant and curable, and all popular books on the subject of his complaint absolutely forbidden. Wholesome diversion and entertainment should be encouraged, but all sexual excitement carefully guarded against. Regulation of the sexual functions, and natural intercourse is of itself capable of effecting a cure. The internal use of camphor, lupulin, bromides, nux vomica, etc., may perhaps exert a beneficial influence, acting symptomatically, but they have no effect upon the disease itself.

Calomel Subcutaneously in the Treatment of Syphilis.

Kopp and Choten (*Viertelj. f. D. u. S.*, 1886, 4, II.) at Neisser's clinic in Breslau made trial of Lorenzo's method of calomel injections in the treatment of syphilis. The cases numbered 263, and the authors were well satisfied with the result of the treatment. The whole number of injections given to these patients was 1,523, and only 72 abscesses were observed. After some experiments, the authors came to the conclusion that the best fluid for injection was yielded by the following formula:

℞ Hydrargyri chlorid. mit. (vapore parat.).... ʒ iv.
Sodii chloridi..... ʒ i.
Aquæ destillat fl. ʒ ij.

S. Injection.

Four injections in two sittings at intervals of one or two weeks sufficed to disperse the syphilitic products. Owing to the minimal quantity of table salt in the mixture, some sublimate is formed which prevents the development of micro-organisms, while the transformation of the calomel into sublimate is favored. The instruments employed must be carefully cleansed, and the injection given into the subcutaneous tissues three centimetres behind the trochanter, after lift-

ing up a fold of skin. The advantages of this method are evident: sure effect, small number of injections required, and cheapness of the drug. But its disadvantages cannot be denied, namely: the formation of abscesses, pain, uncertainty of dosage (because the fluid does not remain uniform even on shaking and a portion always adheres to the instrument), and relapses as with every other method.

The Treatment of Phosphaturia.

A. Bloch contributes an article on this subject to the *Centralblatt f. d. ges. Therapie*, 1886, No. 10. He says: The nature of pathological phosphaturia consists in this, that, owing to the morbid nutrition, the quantity of acids is diminished, and therefore the uncombined alkaline substances are precipitated in the urinary passages. This kind of urine is turbid when passed, deposits an abundance of crystalline and amorphous earthy phosphates, and has an alkaline or neutral reaction. When warmed and acidulated with a few drops of hydrochloric acid, it becomes clear. Phosphaturia is of frequent occurrence as a sequel of chronic gonorrhœa. It is evident that this condition, which often leads to cystitis, could be effectively treated by the exhibition of acids. But if we bear in mind that such treatment would require large, indeed toxic doses of hydrochloric and phosphoric acids, we shall abstain from the use of these remedies. B. has seen good results from the employment of lactic acid, as in the following prescription:

R. Acidi lactici.....gr. xlv.
 Aquæ font.....fl. ℥ vi.
 Aquæ menth.....fl. ℥ ij.

M. S. Two to three tablespoonfuls in half a tumbler of soda-water every two hours.

Although in the first few days, owing to the increase of the sediment, the condition seems to be rendered worse, the effect is all the more striking when the treatment is continued.

Urethral Calculi.

J. Neumann (*Wiener Allg. med. Zeitung*, 1886, Nos. 50-52) reports three cases observed at his clinic which prove that this condition may be mistaken for gonorrhœa. Two patients had swelling of the integument of the penis with purulent discharge, pain during micturition, and the third patient had paraphimosis in addition. On account of these symptoms, the patients were sent to the clinic for syphilis. The calculi were grasped with forceps through corresponding incisions into the urethra, extracted, and the wounds cleansed. If the calculi cannot be seized, they should first be comminuted and then extracted, and only if this is not feasible should they be pushed into the bladder and then treated like vesical calculi. Such concretions are usually vesical and renal calculi floated to their present location; autochthonous urethral calculi, such as occur with strictures and fistulæ, are rare.

HOROVITZ.

VIENNA.

CASE OF COPAIBA ERUPTION.

To the Editor of the *Journal of Cutaneous Genito-Urinary Diseases*.

SIR:—The following case of generalized eruption from the ingestion of copaiba came under my observation recently. Dr. Cartledge, of this city, called me in consultation to see a patient suffering with a peculiar eruption.

The patient, a florist, 28 years of age, unmarried, presented himself at the doctor's office September 1st with an acute attack of gonorrhœa; he was advised to take a desert-spoonful of the following mixture every four hours.

℞ Balsam Copai bæ,	
Spts. <i>Ætheris Nitrosi</i>	āā ʒ i.
Liquor. Potass.....	ʒ iss.
Sacchari.....	gr. xx.
Mucilag. <i>Acaciæ</i>	ʒ iss.
Spt. <i>Lavandulæ</i>	q. s. ad ʒ iv.

Enlarged inguinal glands were painted with tinct. iodine; patient did well till September 5th, when an eruption made its appearance, extending from the surface that had been painted with the iodine, down the thighs: there was at this time some febrile disturbance and nausea: the gonorrhœal discharge stopped.

Two days later, when I first saw the patient, the whole surface of the skin was covered with a bluish-red erythematous rash, the only portions not affected were a few isolated circular spots of normal-colored skin about the size of a fifty-cent piece, situated about the thighs and abdomen; the eruption ended abruptly at the margin of these spots. There were no subjective symptoms. On the fourth day after discontinuing the copaiba mixture, the dermatitis had entirely disappeared; temperature normal; the urethral discharge again made its appearance. The case is an interesting one from the fact of the absence of subjective symptoms, the amount of surface involved in the eruption, and the peculiar isolated spots of perfectly natural skin.

J. CLARK MCGUIRE, M.D.,

Dermatologist to Louisville City Hospital.

Selections.

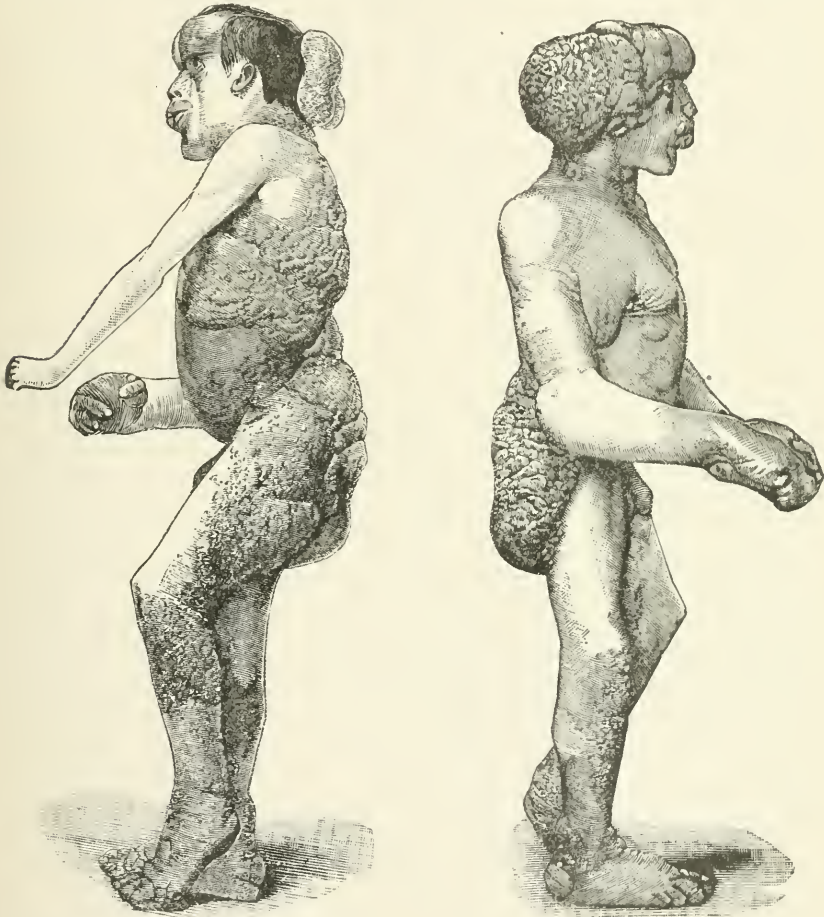
THE "ELEPHANT MAN."

THE *British Medical Journal*, December 11, 1886, gives an account, with illustrations, of a most remarkable case of congenital deformity of the skin and bones, which are of such an exaggerated nature as to secure for him the appellation of the "Elephant Man." Within a few years the disease has made great progress, until the condition represented in the accompanying woodcut has been developed. The "Elephant Man" is a native of Leicester, and is about 27 years of age. The bony exostoses on his frontal bone, combined with a deformity of the superior maxilla, gives a trunk-like appearance to the nose and upper lip, the profile of the face suggesting the profile of an elephant's head. He is short, and lame through old disease of the left hip-joint. The integuments and the bones are deformed. The subcutaneous tissue is greatly increased in amount in certain regions, where the integument is consequently raised prominently above the surrounding skin. This tissue is very loose, so that it can be raised from the deeper parts in great folds. In the right pectoral region, at the posterior aspect of the right axilla, and over the buttocks, the affected skin forms heavy pendulous flaps.

The skin is also subject to papilloma, represented in some parts, as in the right clavicular region, by a mere roughening of the integument; over the right side

of the chest, the front of the abdomen, the back of the neck, and over the right popliteal space, the growth is small; on the other hand, great masses of papillomata cover the back and the gluteal region. The eyelids, the ears, the entire left arm, nearly the whole of the front of the abdomen, the right and the left thigh, the left leg, the back of the right leg, and the penis and scrotum are free from disease.

The deformities of the osseous system are yet more remarkable. The cranial



bones are deformed and overgrown, so that the circumference of the patient's head equals that of his waist. Bony exostoses spring from the frontal bone, the posterior part of the parietals, and the occipital. Irregular elevations lie between these bosses, and all these deformities are very unsymmetrical. The right superior maxillary bone is greatly and irregularly enlarged. The right side of the hard palate and the right upper teeth occupy a lower level than the correspond-

ing parts of the left side. The nose is turned to the left and the lips are very prominent. A connective-tissue growth was removed four years ago from the front part of the right upper jaw. All the bones of the right upper extremity, excepting the clavicle and scapula, and the bones of both feet, are hypertrophied, without exostoses.

The patient can give no family history of similar deformity, but declares that his mother was knocked down by an elephant, in a circus, when bearing him. The hypertrophy of the bones existed ever since he can remember; the thickening of the skin and papillomatous growths were very trifling in degree of development during childhood. The papillary excrescences are increasing rapidly, and hypertrophy of the integuments of the right hand is causing it to become slowly crippled. General health is good.

MEDICO-LEGAL QUESTIONS IN RELATION TO THE LAW OF DIVORCE.

THE medico-legal aspects of the recent case which has unfortunately occupied so much of the public attention has raised some new questions of considerable importance, and the decisions in this and the previous trial establish conclusions not previously arrived at in any case hitherto tried.

The medical evidence was given throughout on both sides with great judgment and scrupulous accuracy, and appears to leave no room for cavil. From the facts stated in evidence, it appears that the husband had been operated on, both before and after marriage, for perineo-urethral fistula, due to gonorrhœa contracted in earlier life. In consequence of the condition of the husband, marriage was not consummated until four months after the ceremony. A fortnight after this consummation the wife suffered from a persistent vaginal discharge. She subsequently suffered from an attack of cellulitis. After she had recovered from this, the husband proposed to resume cohabitation; the wife refused, and ultimately appealed to the Court for protection. The trial took place in 1884 before Sir James Hannen, who, having heard the evidence of all concerned and numerous skilled witnesses, considered that she should be protected; the jury agreeing to that view, he gave judgment accordingly. This was appealed against, but the upper Court confirmed the judgment. This judgment was novel and important; it established this point, that the result of a former specific attack continuing, and being liable to injure the wife, would entitle her to a judicial separation. And it may, perhaps, be assumed that the same rule would hold good for both sexes. It appears that the judge did not require, in order to establish "cruelty," that there should be a recent specific infection. In this case, the surgeons called considered that pus would run along the urethra in cohabitation, and this they held would be fraught with danger; this view is in accordance with all modern teaching. Gynæcologists recognize that serious inflammatory attacks, and irritations of the genital tract are liable to follow cohabitation with those who have had gonorrhœa, although all specific conditions have disappeared. This judgment is far reaching, but was, during the second trial, held to be a good one, which could not be disturbed. The question naturally arises, what length of time elapses before a specific attack (gonorrhœa) can wear itself out? This question did not affect the judgment above mentioned; but it is of much practical interest, and, in view of this judgment, important.

In the second trial, attempts were made to reopen the case, but these were

checked by the judge. Another theory was, however, put forward as a possible explanation of the cellulitis; this was a suggested miscarriage shortly before the inflammatory attack. The consultant, however, who saw the case seven days after this was alleged to have taken place, not only did not find the slightest evidence of miscarriage, but on the contrary found the os and cervix in accordance with the nulliparous state. Later on in the case, in dilating the cervix, it was ascertained to have the characters of congenital stenosis. The evidence on the other side was largely based on the suspicions of a nurse who *thought*, from the occurrence of severe pain and a free hemorrhagic discharge, that a miscarriage had occurred—a suggestion negatived by the medical evidence and easily rejected by both judge and jury. Every medical man is aware that cellulitis is very frequently associated with severe pain and free discharge, and the freer the discharge the less the internal swelling, this being nature's mode of relief. This and other phases of the case emphasize anew the risks which beset practitioners in their daily work, and the necessity for the strictest observance of professional discretion in their relations to patients of whatever position in life.—*Brit. Med. Journal.*, Dec. 25, 1887.

THE TREATMENT OF BLENNORRHAGIC CYSTITIS.

THE conclusions of a contribution by Dr. Desnos to the study of the diagnosis and treatment of gonorrhœal cystitis, which appeared in the *Bull. Gén. de Thérap.*, October 15, 1886, are as follows:

1. Blennorrhagic cystitis has its site in the cervical portion of the bladder; it is always associated with a deep urethritis, but the latter could not alone give rise to all the symptoms of cystitis present.
2. In the beginning of a blennorrhagia, certain patients experience frequent desire to micturate, which might be regarded as due to a cystitis, but the short duration of the symptoms present, and the absence of others pointing to cystitis, make the diagnosis clear.
3. In chronic cases, the diagnosis between blennorrhagic and tubercular cystitis is at times impossible when it succeeds an old gonorrhœal inflammation.
4. A certain number of cases designated as cystalgia, neuralgia of the neck, are nothing more nor less than uncured cases of blennorrhagic cystitis. In certain cases, even after complete cure, a certain painful sensation persists for a very long time.
5. The treatment of acute cystitis by means of emollients seldom succeeds, and the disease persists. The neck of the bladder should be treated early, in the acute stage, by instillations of nitrate of silver. A sharp reaction occurs at the first application, but the amelioration is rapid.
6. In chronic cases, washing out the bladder is a measure of little worth, and can bring back the disease to its acute stage. General treatment is an excellent adjuvant to the local treatment, which is indispensable.
7. This local treatment should consist in instillation of substances against the neck, which will modify the disease.
8. Corrosive sublimate, in the strength of from 1 : 250 to 1 : 500, produces severe pain, which continues for a long time, and its effects are slower than those of nitrate of silver.
9. Iodoform dissolved in oil, or suspended in glycerin, can be applied without causing pain, but its effects, though satisfactory, appear slow and uncertain.

10. The hydrochlorate of cocaine relieves the painful conditions of the bladder for a short period of time only, but applied about the neck of the bladder before the instillation of a caustic, it modifies materially the pain.

11. From all points of view, nitrate of silver possesses an incontestable superiority over other therapeutic agents.

IODOFORM POISONING.

SINCE we have learned to accomplish the same end with a smaller quantity of iodoform than formerly thought necessary, cases of poisoning from the drug have appeared to grow less frequent. Dr. Willemer says, in No. 50 of the *Centralblatt für Chirurgie*, 1886, that nowadays we scarcely ever hear of iodoform poisoning in young people. He reports a case occurring in a man of 68 years, whose thigh he amputated on May 4, 1886. Four grams of iodoform were powdered over the stump, but much of this was washed away by the blood when the Esmarch was removed. A ten-per-cent iodoform gauze was used as a dressing.

On the second night after the operation, the patient became restless and could not sleep, and the following night the same restlessness reappeared and increased. The symptoms were such that it was difficult to exclude tubercular meningitis. During the next six days, the patient passed fæces and urine in bed, and would only take nourishment when forced. From the seventh day on, he was entirely out of his mind, and had hallucinations of hearing followed by delirium. Much the same condition persisted until the thirty-sixth day, when improvement began to take place slowly, and becoming restless at the approach of evening. On the sixty-fourth day only had he so far recovered as to warrant his discharge. In October he was reported entirely well. The treatment consisted in removing the iodoform as much as possible, giving morphine by hypodermic injection, and forcible feeding.

Out of seventy-nine cases which were accessible to the author, he found 34 or 43% occurring in persons of 50 years or over, 29% of them being between 50 and 60, 50% between 60 and 70, and 21% over 70 years of age. Fifty-three per cent of those over fifty years of age died from the effects of the poisoning. In most cases, the symptoms appeared first in the second week. An earlier beginning denoted a severe case. Death took place once in the sixth week, twice in the third, and in the other fatal cases, on an average of seven or eight days from the first onset. The third day is considered an especially fatal one.

CARBOLIC-ACID PULVERIZATIONS IN THE TREATMENT OF ERYSIPELAS.

THE employment of carbolic acid in the treatment of erysipelas has been recommended for some time. At a recent meeting of the Société Médico-Pratique, Dr. Ory communicated the two following cases, which serve to demonstrate the efficacy of carbolic-acid pulverizations, which was the only treatment used. The first case was that of an infant of three months old, suffering from erysipelas following vaccination. A fortnight had elapsed since vaccination when Dr. Ory was summoned. The little patient was feverish, depressed, and convulsed. The right arm was swollen, with a red patch about the size of the palm of the hand, in the centre of which was a vaccine pustule, covered by a scab in process of desiccation. Collodion, mixed with castor-oil, was applied to and around the red patch, in order to check the spread of the erysipelas, and an anti-spasmodic

treatment was followed during the night. Finding the collodion applications ineffective in preventing the spreading of the redness, Dr. Ory had recourse to the treatment indicated by Prof. Verneuil. The child was wrapped in cotton-wool. Carbolic-acid pulverizations were then used in every hour for five minutes; a two-per-cent solution was used; considerable improvement occurred. The convulsive movements ceased, diarrhœa disappeared, and the temperature fell from 40° to 38°. On the following day, only those parts where the collodion still remained were red; it was removed, and, by the evening, all traces of erysipelas had vanished. Rapid recovery, without any relapse, ensued. The number of pulverizations was gradually reduced (four in twenty-four hours on the fourth day), and all treatment was discontinued on the fifth. The second case was that of an old man, aged 69. The patient was ataxic and subject to obstinate constipation. The perineum and gluteal regions were attacked by erysipelas. The carbolic-acid pulverizations, applied in the manner above mentioned, had a satisfactory result. From the first evening the pain diminished after each pulverization, and on the third the tissues had almost recovered their normal coloring, and there was less fever. Dr. Ory concluded by stating his opinion that carbolic-acid pulverizations might be used, to the exclusion of all other internal treatment, for combating erysipelas.—*Paris Cor. Brit. Med. Jour.*

URETHRAL SUTURE.

DR. TERRIER related, at the October meeting of the Société de Chirurgie, a case of foreign body in the urethra, which he had removed by a long urethral incision. He attempted the reunion of the urethral mucous membrane by first intention, applying the sutures to the walls of the canal. He took the precaution, however, to leave the skin wound in the perineal and scrotal region widely open, fearing infiltration of urine in case of failure of union in the urethra, and introduced a soft catheter *à demeure*. Healing was complete on the twentieth day. The urine was rendered aseptic by the internal use of the borate of soda. The author did not know of analogous cases. In the discussion which followed, it was the general opinion that the suture was useless or unnecessary.

Dr. Verneuil admitted the benefit of the immediate suture in certain cases, in the penile portion for example, and believed that urethrorrhaphy in this situation was a good operation in view of the difficulty in healing fistulæ in this region. He thought it less useful for the deeper portions of the canal (scrotal, perineal, and bulbar).

The President, Dr. Horteloup, thought that the suture of the urethra could not give better results than the classic method in external urethrotomy. Besides, he regarded the suture of the perineum as dangerous, because of possible infiltration of urine.

In closing the discussion, Dr. Terrier said he had only intended to speak of the suture in cases of foreign bodies and urethral calculi, and not in stricture. He also feared the suture of the perineum and of the skin. If he should practise it, he would take the precaution to place a small drainage tube between the sutured urethra and the united skin.—*Le Progrès Médical*, Oct. 30, 1886.

SYPHILIS AND PREGNANCY.

DR. HIRIDAYEN, surgeon to the Maternity Hospital at Bordeaux, has just completed a series of observations on the influence of syphilis upon both the woman in the pregnant state and upon the foetus, reaching the following conclusions:

1. In the lying-in service at Bordeaux, the proportion of women who are syphilitic reaches five per cent.

2. Five-sixths of these are unmarried women.

3. Syphilis has an influence on the pregnant state by adding a complication, and by bringing about usually a premature birth.

4. The stage of the disease has an important influence.

5. Out of eight pregnancies in syphilitic women diseased for one or more years, two children lived, but were weakly.

6. Out of twelve women infected in the first four months of gestation, all children were born dead.

7. Syphilis acquired from the fourth to the sixth month of pregnancy is also very dangerous for the foetus, the half at least succumbing.

8. Syphilis acquired during the last three months of gestation gives a little over fifty per cent of living children, and is less dangerous to the foetus than is maternal syphilis before impregnation.

9. Out of thirty-three pregnancies in syphilitic women, eight resulted in the birth of living children. Three-quarters terminated in the death of the foetus.

10. Syphilis may cause difficulties in labor and complications following it, but this is relatively rare.

11. To be efficacious, antisyphilitic treatment should be begun from the very commencement of pregnancy and continued during the whole term. Treatment should be persistently carried out in these cases to have an effect on subsequent pregnancies.—*Gaz. des Hôpitaux*, January 4, 1887.

LUPUS VULGARIS.

DR. FELIX BLOCK, in a clinical contribution upon the etiology and pathogeny of lupus (*Viertelj. f. Dermat. und Syph.*, 2, 1886) gives the results of his observation of 144 cases. 114 patients, that is 79 per cent, were affected with some form of tubercular disease, either prior to the attack of lupus or following it. The tubercular manifestation occurred anteriorly in over one-fourth of the cases. The author, therefore, believes that lupus is a chronic tubercular disease of the skin, occasionally of some of the mucous membranes. It occurs in those who have inherited or acquired tuberculosis, but also those who are in other respects healthy. In all cases it is, however, a tubercular disease. As regards sex, 98 of his patients were female and 46 male.

In over a quarter of the cases, the disease first appeared in the first five years of life, and in over half in the first ten. From the twenty-fifth year on, lupus seldom begins, but between the ages of forty and forty-five and it commences somewhat more frequently. The site of the first outbreak could be pretty accurately determined in 135 cases, and it was found that 14 cases began on mucous membranes; 10 on that of the nose, 2 on the conjunctiva, and 1 each in the throat and larynx. Of the 121 upon the skin's surface, 79 were upon the head, 29 being on the cheeks and 28 upon the nose. 20 were on the neck, 12 on the upper extremity, 6 being on the hand, and 10 upon the lower extremity. Considering all the cases together, we find that the disease was located most frequently upon the cheeks, then next in frequency upon the nose, neck, upper lip, and hand. The mucous membranes were affected in 50 cases; that of the nose, 41 times; palate, 14; lip, 11; soft palate, 8; gums, larynx and conjunctiva, each 7, and the throat 4 times.

Sachs found (*ibid.*) that in 105 patients there were only fifteen in whom no past nor present, nor hereditary tuberculosis could be found. Under various forms of surgical treatment, 42 per cent were cured; relapses took place in 55; 44 per cent of the cases were treated by scraping and with thermocautery, the subsequent dressing being iodoform and iodoform ointments.

THE TREATMENT OF THE EARLY STAGES OF SYPHILIS.

DR. LIPP believes that the present method of early treatment of syphilis is still inadequate. Some physicians believe in attacking the disease energetically from the very onset, while others put off treatment until constitutional symptoms show themselves. Some of the first category have recommended excision of the primary lesion and extirpation of the infiltrated glands—an operation not easily carried out in a great number of cases, and one in which successes are reported only from scattered cases. The customary method of treating the disease only after constitutional symptoms have appeared has brought forth no essentially favorable results. The antidote to the poison must be employed quickly and in the right place. The physician must know the exact quantity of the drug he wishes to introduce into the system, and herein lies the advantage of the subcutaneous method. Another advantage offered is the possibility of bringing the specific remedy at once into contact with the lymphatic glands and nodes, where, after the initial lesion, the syphilitic process has its seat.

Dr. Lipp does not hesitate to say that in the treatment of syphilis the subcutaneous method seems to him indispensable. No other method so quickly softens and reduces lymphatic swellings. He employs for injection the tannate of mercury, as this preparation has given the best results in his hands, and never increases the daily dose beyond one-third grain.—*Deutsche Med. Zeitung*, No. 82, 1886.

SYPHILIS HÆMORRHAGICA NEONATORUM.

FOR over four years Dr. Uraček (*Deutsche Med. Zeitung*, No. 82, 1886) has been studying in Vienna the pathological anatomy of syphilis, especially in its hereditary form. He has found in the different organs, amongst other well-known changes, peculiar hemorrhages. Out of 132 deaths among infants of syphilitic mothers, slight hemorrhages were distinguished in 44 cases. There were only 19 cases, however, in which the positive diagnosis of syphilis could be made. Of these children, 18 came into the world alive, and only one was born dead, but none lived very long. Ten died within a quarter of an hour, and the remainder forty-eight hours after birth.

On autopsy, a great variety of changes were found hepatitis, perinephritis, infiltration in the lungs, changes in the bones, etc.

The author examined the blood-vessels histologically, choosing such portions as had been involved in the hemorrhages, and found them especially in these locations, altered.

Particularly was this the case in the veins of medium calibre. The lumen was often but slightly lessened, and again almost obliterated. Not much importance is placed upon the fact of arteritis being found in a few cases. The hemorrhages were always multiple, and distributed as follows: skin and subcutaneous connective tissue, 19; lungs and pleura, 18; heart, 10; kidneys, adventitia of the carotid and other large vessels, and retroperitoneal cellular tissue, 5; and the mucous

membrane of the mouth, 2 times. The lesions produced were ecchymoses which resulted from a diapedesis from the small veins and capillaries.

ORCHITIS VARIOLOSA.

DR. CHIARI, of Prague, says (*Deutsche Med. Zeitung*, No. 80, 1886) that the appearance of parenchymatous orchitis in variola is not at all rare.

Wagner, of Leipzig, has quite frequently found in the parenchyma of the testicle, in variola, small reddish-gray nodules which later became yellowish. Chiari has examined the testicles in fifteen cases of variola and has in every case been able to make out the macroscopic nodular condition characteristic of the presence of the affection, and he concludes that orchitis variolosa is an almost constant accompaniment of the variola process in youth.

The more recent the case the less clearly defined do the separate nodules appear to be. At times they are exceedingly small, while again they may be clearly made out through the scrotum, as swellings half the size of a pea.

Three groups of the affection are described: variola sanata, the stage of excitation, and that of efflorescence. In the case of variola sanata, three histological zones were to be distinguished: the zone of total necrosis, the zone of infiltration, and the zone of excitation.

In the centre, the septa between the separate seminal canals were much widened, and all the tissue was necrotic. In the second zone was found a small yellow infiltration of high degree which proved to be dead tissue; on the periphery of this zone the epithelium appeared filled with lymph. In only two cases did he observe micro-organisms in the seminal canals.

As the development of the affection of the testicles keeps pace with the exanthema upon the skin, Chiari concludes that both phenomena are of the same nature.

Further, according to Weigert's observations, nodular changes are found in other organs in variola; as, for instance, in the muscular substance of the heart.

PSEUDO-GONORRHOËAL INFLAMMATION OF THE URETHRA AND EPIDIDYMIS.

DR. MAX BOCKHART (*Monatsheft für prakt. Dermatologie*, No. 4, 1886) comprehends under the term pseudo-gonorrhœal urethritis that which is usually called catarrhal urethritis, and which is produced without the presence of gonococci and which is distinguished from gonorrhœa proper by its short course and absence of the bacilli.

He demonstrates that a certain percentage of these catarrhal inflammations of the urethra are caused by bacteria. As such, he describes, first, a kind of staphylococci which, like the gonococci, appear mostly as diplococci, but are considerably smaller. He has found these four times out of eleven cases of catarrhal urethritis. He produced cultures of them in meat-peptone agar-agar, made alkaline with phosphate of sodium. To demonstrate their pathogeny, he inoculated a medical student from a culture, and produced a urethritis which, without treatment, was well in nineteen days.

Another inoculation from a sheep's blood-serum culture caused a severe inflammation, requiring treatment, but was well in eleven days.

Dr. Bockhart believes that his observations answer Neisser's question as to

whether there exist other schizomycetes peculiar to the urethra. He adds the suggestion that perhaps every form of urethral epididymitis is of a bacterial nature.

ELECTROLYTIC CAUTERIZATION IN LUPUS.

In a letter from Vienna to *Le Progrès Médical*, Dr. Liebowitz says that at a recent meeting of the Imperio-Royal Medical Society, Drs. Gärtner and Lustgarten presented an interesting communication on electrolytic cauterization in cases of lupus. The lesions produced by the electric current are due, first, to the fact that the tissues themselves are subject to a phenomenon of electrolytic decomposition, and secondly, to the chemical effect of electrolysis and to the so-called "cones," of which the chemical affinity is very strong on account of the "status nascendi" in which they are found. Beneath the cathode hydrogen is developed, to which Hoppe-Seyler attributes a great force, and also alkalis. It was therefore evident that the electrolytic effect of the cathode should be considered as a sort of cauterization by the protoxide of potassium. The skin covered by the electrode is rarely destroyed. The points cauterized are those at which the current meets with the least resistance. After the destruction of the epidermis by the alkali, the effect is greater, the cauterization continuing in the deeper parts, while the current has no effect on the poorly conducting adjacent tissues. The electrode being applied to a portion of the normal skin and others to portions deprived of epidermis, or where the epidermis is loosened, an effect only is noticed in the latter, as the current here meets with the least resistance. When the necessary precautions are taken, no pain is caused.

Lustgarten has cauterized seven cases of lupus in Prof. Kaposi's clinic; six on the extremities, and one on the face, employing a current of from five to eight milliamperes produced by a chromic acid battery of twenty-four elements.

To regulate the electric current, they employed the rheostat of Gärtner. The positive electrode consisted in a fixable rheophore covered with a sponge. For a negative electrode they employed a disc of fine silver surrounded by a border of hard rubber, to prevent cauterization at the edge of the metallic electrode. The duration of the action of the current was ten minutes. On taking away the electrode, the lupus spot is seen to be excoriated, and to pour out a glutinous strongly alkaline fluid, while the sound skin under the electrode remained intact. After a few hours, the cauterized spots are found already covered with leathery crusts of a bluish color, beneath which healing takes place after a few days without suppuration.

BACTERIOTHERAPY.

DR. VINETA-BELLASERRA (*Revista de Ciencias medicas*, December, 1886) has tried the treatment of lupus by the local application of the bacterium termo. Lupus being now generally regarded as a local tuberculosis, the author was led to attempt this plan of treatment by the experiments of Cantani, and others in pulmonary and laryngeal tuberculosis. The bacteria of putrefaction are applied to the lupus patch which has been previously scarified, by means of cotton soaked in the fluid of a bacterium termo culture. The cotton is to be covered with a sheet of gutta-percha and held in place by strapping, being renewed every twenty-four hours. The scarifications are repeated every second day.

The author relates three observations, but concludes by saying that up to the present time the application of bacterium termo to tubercular lupus has, from a therapeutical standpoint, given him no favorable results.

CAMERA OR CHIMÆRA.

THE *Camera*, a journal devoted to photography, recently recorded two observations which, if verified, might greatly aid in the early diagnosis of eruptive diseases. The negative of a child having apparently clear skin, showed the face to be covered with an eruption. Three days later an eruption of urticaria appeared.

In the second case, the child's photograph showed spots upon his face a fortnight before an attack of small-pox. In many affections there is an indistinct mottling of the skin before the characteristic eruption actually appears. If this condition can be intensified in a photograph of the patient, it may aid in forming an early diagnosis. Photographers, however, are frequently troubled by these plates with "measles," when no eruption is present or afterward appears upon the skin.

Items.

PERMANGANATE OF POTASH IN ECZEMA.—Dr. Lawrence, of Batesville, Ark., recommends in eczema the application of permanganate of potash in strength of five and ten grains to the ounce of water.

STRICTURE OF THE FEMALE URETHRA FROM LUPUS.—Dr. Herman recently reported at the London Obstetrical Society a case of this rare condition, of which only two previous cases appear to have been recorded. Retention of urine had occurred, the meatus was occluded, one labium minus was hypertrophied, the other perforated, but there was no ulceration visible. The channel was opened with a trocar, and bougies were then used.

SPERMATORRHŒA.—Fürbringer finds that a previous gonorrhœa is the cause of spermatorrhœa in the majority of cases he has observed. When of gonorrhœal origin, the discharge is not mixed with the secretion of the prostate, is devoid of the characteristic odor of the seminal fluid, and contains no Böttcher's crystals, while all these are present in neurasthenic spermatorrhœa.—*Medical News*, November 27, 1886.

CHOLESTERIN IN THE STRATUM GRANULOSUM.—Lewin has shown (*Berlin. Klin. Wochenschr.*, No. 2, 1876), that cholesterin is present in the stratum granulosum of the epidermis, as well as in the sweat ducts. Small globular bodies are also found between the cornified cells which give the same reactions.

ORGANIC STRICTURE OF THE URETHRA is said by Dr. W. Page McIntosh, of New Orleans, to be comparatively rare of gonorrhœal origin in full-blooded negroes. Traumatic stricture, though, is not infrequent in the negro. The causative affection is found to be of great frequency in the black, but the course is said to be milder and more amenable to treatment, often yielding to the simplest remedies.

JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

VOL. V.

APRIL, 1887.

No. 4.

Original Communications.

CASE OF UNIQUE LINEAR DISTRIBUTION OF CUTANEOUS LESIONS
OF UNKNOWN NATURE.

BY

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THE case of "lichen ruber moniliformis," or, "bead necklace-like lichen planus," recently reported (with portrait) by Kaposi (*Viertelj. für Dermatologie und Syph.*, 1886, 4 Heft, 1 Hälfte), remarkable for the peculiar striated arrangement of the lesions, calls to mind a case which was brought to my notice a few years ago by Dr. A. T. Hudson, physician to the City Hospital in Stockton, California. The lesions were arranged in a singular manner, as the following notes and sketch, for both of which I am indebted to Dr. Hudson, will show. The history is meagre. The man's name was Francis Grinnell, aged 35, who having travelled from San Francisco to Stockton, became sick and despondent, and attempted suicide by taking morphia. He made the statement that he took two drachms of morphia dissolved in water. The next day he was unable to walk, suffered from pains in the limbs, back, and stomach, and vomited all food and drink. He went to jail as the only refuge at the time, where he was first seen by Dr. Hudson. He remained in jail two nights and then entered the city hospital, where,

while in a bath, the cutaneous lesions were first discovered by the attendant. No information could be gained from the patient as to their history or cause; in fact, he seemed not to be aware of their existence. The spots were about the size of a dime and circular, and were neither raised nor roughened on the surface. They appeared to be simply circumscribed, well-defined macules of a dull reddish color. They were on the back and numbered fifteen on each side of the spine, situated symmetrically, about an inch on either side of and parallel with the spinal column, running linearly from the first dorsal vertebra to the sacrum. In addition to these thirty lesions, there existed six others in the form of two triangular groups of three each, situated in the lumbar region on either side of the linear lesions. There were no subjective symptoms. He remained in the hospital about a fortnight, and then left improved in health. Five days later he was found dead in his room, having committed suicide with morphia and chloroform. No post-mortem examination was held, but on examination of the skin the spots still existed and were noted to be even more distinctly defined than during life.

Dr. Hudson states that neither he nor the other physicians of the hospital had ever seen or heard of a similar case. No opinion as to the diagnosis or nature of the disease is offered. The view of the lesions being hemorrhagic occurs to me as being the most probable, due to the shock to the nervous system from the first dose of morphia. The case, however, is chiefly interesting on account of the extraordinary and unique arrangement of the lesions, seated solely over the region of the nerves springing from the spinal cord, as well as for their remarkably exact symmetry. It is a striking instance of a neurotic cutaneous manifestation. I may add that I have never encountered nor read of a like distribution of lesions.

MERCK'S CONCENTRATED LACTIC ACID; SOME OF ITS USES IN DERMATOLOGY.

BY

J. P. KNOCHE, M.D.

ABOUT twelve months since, I read an article by a noted Berlin professor, pertaining to the use of Merck's concentrated lactic acid in the treatment of epitheliomatous cancer, and its local action on structures other than epithelioma. The article referred to first led me to use this remedy in a number of cases other than epithelioma; in the following I will cite and give a short sketch of some of the cases in which I used it:

February 6, 1886, Mr. A., male, aged 46, married (one child 7 years old, strong and healthy), occupation railroad official, called at my office to be treated for a disease of the hands and feet which he stated had existed for seven years, during that time annoying him very much. He had had the advice of several physicians, and used numerous applications and internal remedies; also a course of treatment at the Hot Springs. The severity of the disease fluctuated, at times seeming as if about to recover, then again relapsing to its former state. One of the most annoying symptoms was itching. Upon examination I found the following condition: an excessive and somewhat circumscribed irregular thickening of the epidermis of, and involving almost the entire surface of the palms of both hands, parts of the anterior and inner surface of the thumb and fingers; of the feet, the toes and plantar arches were involved in a like manner. A patch of chronic eczema involving the surface was found between the internal malleoli and the base of os calcis. Another, almost circular, and about one and one-half inches in diameter, located on the posterior surface of, and near the elbow of the right arm. A similar patch, involving about one-third of the back of the right hand, extended from the wrist to and including the metacarpo-phalangeal joint of the little finger. The dorsal surface of the middle and ring fingers, and great toes, were affected in a like manner. The palms of the hands were not fissured, but parts of the dorsal surface of the middle and ring fingers, the spots spoken of on the back of the right hands, and those on the feet, were; the one on the right forearm was not. I diagnosed the disease of the palmar surface of the hand and the plantar surface of the feet as "tylosis," the other, as I have already stated, as chronic eczema. The former condition in this case evidently developed spontaneously, as the occupation of the patient was not nor is such as to cause it.

I here append a translation made from Kaposi, "*Hautkrankheiten*," page 532.

"We sometimes see tylosis develop spontaneously on the glans penis or on the palms of the hands and backs of the fingers of persons whose vocation is not such as would cause this condition (clerks, ladies, etc.). I have seen this tylotic condition develop within a few months and continue to extend, and after the lapse of three or four years disappear spontaneously. I have seen it, however, more frequently continue its course uninterrupted for a much longer period.

I also append the following from Hebra und Kaposi, "*Hautkrankheiten*," vol. ii., page 25.

"We sometimes find tylotic formation that cannot be attributed to any special cause, as, for example, on the glans penis and on the inner

border of the arch of the foot. They usually differ from those tylotic formations that are produced by pressure by their uneven rough surface, darker color, and their tendency to peripheral extension."

One of the first energetic measures I employed in treating the tylosis was a caustic potassa solution. This, when cautiously applied, succeeded in macerating, as it were, the dense horny layer. This procedure did very nicely, but it has several objections. One of them is, that the derma is more readily attacked than the epiderma; wherever there may be a fissure or only slight abrasion, and the solution comes in contact with it, more or less destruction of tissue is sure to follow, the consequent pains being very severe. Recognizing that I was making very slow and painful progress, I ceased this treatment, and applied simple cerate to the hands for several days until the soreness caused by the caustic potash solution had been relieved. I then applied an alcoholic solution of hydrg. chlor. corros. (about ten gr. to the oz.). I applied it well to the palms of the hands, and from what I had heard and read, expected to see the objectional horny layer lifted off in a few days, but to my surprise I found that I had only succeeded in producing an ulceration in two places and keeping my patient up all night suffering with intense pain. It was at this time that I read of the medicament forming the subject of this paper. I immediately ordered some to try in this case, for if it would produce disintegration of the epithelium and, as the author claims, not attack other tissues—why, that was just what I wanted. I applied it to the palms, rubbing it well in. In fifteen minutes I was able to easily remove by gentle scraping (with a knife) quite a quantity of the epithelium. Seven hours later I again applied the acid, and within from twenty-four to forty-eight hours every particle of the tylotic formation peeled off, leaving the palm of the hands as smooth and soft as that of a babe. A like result was obtained on the fingers and feet. This condition, I am sorry to say, lasted only about six days (the patient in the mean time using ung. zinc. oxidi benz., changing off with tar ointment), when I noticed that here and there in spots on palm of the hands and also on the fingers the epidermis began to thicken. I immediately applied the acid. The same result followed as before. In this manner I continued using the ointment, and when necessary the acid, and at the end of about the fifth month I had the satisfaction of seeing the hands and feet completely cured. That has been eight months since, and so far there has been no return. I would further state that there was at no time a formation of serum between the tylotic formation and the tissue beneath, as would result from the use of hydrg. chlor. corros. sol. The pain was scarcely noticeable; furthermore, when the acid came in contact with an abrasion or fissure, the pain would last only a few moments, no injury resulting,

as the derma was not attacked. A siege of two months was required before the eczema yielded to treatment. The usual remedies were employed.

Mrs. B. called to consult me in regard to yellowish-brown spots on her forehead and upper part of her face. Diagnosis, chloasma hepaticum. I applied Merck's concentrated lactic acid diluted with water, one to three. The second application produced a slight burning tingling pain, as described by patient. After the second application, the surface treated became quite red and slightly inflamed; as soon as the inflammation subsided, which was in about twenty-four or thirty hours, the discolored epidermis began to peel off, but only in spots. I again used the diluted acid until the parts became again inflamed, then ceased; a day or two later the epidermis peeled off nicely, leaving the surface smooth and a pinkish red. I had the patient use oxide zinc ointment for a few days. In about four days she had fully recovered. I will here state that the patient was not permitted to bring water in contact with the parts under treatment until they had begun to desquamate.

Miss E., blonde, called to consult me about small yellowish spots on her face and forehead. I diagnosed it ephelides or so-called summer spots. They were treated as case second and with the same result.

Mr. G., male, age 42, occupation fireman, called at my office to consult me in regard to his hands. I found the following condition: The epidermis had become so enormously thickened that it was impossible for him to more than half close his hand. I pronounced the trouble tylosis, and treated him in the following manner: On the left hand I placed a rubber glove, and the right (which was much the worse) I treated with the lactic acid. My result in this case was just as in the first case. In six or eight days from the beginning of treatment (using the acid pure morning and evening), the tylotic condition had been completely removed; while the other hand improved but little. I then used the acid on the left hand with the same result, as above stated. I do not know if the tylotic condition returned soon after or not, as I lost sight of the patient a few days after I had ceased treating him.

I also used this acid in a number of cases of common warts. I found by taking a pointed instrument (I usually use a tooth pick) and applying the remedy thoroughly, that after three to five hours the top of the wart to the derma would be easily removed, but it required two or three applications a day for several days to remove the prongs of horny epithelium that dip into the corium. The latter applications are always more or less painful, pain produced by the acid coming in contact with the denuded surface, although the tissue was not destroyed, as would be the case if caustic potash or hydrag. chlor. corros. solution were used.

I have used this acid in a number of cases of herpes tonsurans where there were but few patches of it. Also in pityriasis versicolor. I found that in nine cases out of ten one application was sufficient, as five minutes after a thorough application of this remedy I could with a piece of cotton easily remove the epidermis and consequently the disease, as they are both local. I have not had a case of herpes tonsurans of the scalp, therefore do not know how it would act in a case of that kind. The periphery of a herpes tonsurans patch will invariably bleed when subjected to the above treatment.

I would like to mention that in the first case I used the acid about two or three times a day.

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THE DURATION OF THE SYPHILOGENIC CAPACITY IN RELATION TO MARRIAGE.¹

BY

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THE two fundamental characteristics of syphilis as distinguished from other infectious diseases are its prolonged virulence and its susceptibility of hereditary transmission.

These characters are not, however, impressed upon the syphilitic organism during the entire course of the disease; as syphilis advances in its evolution, the virulent principle gradually loses its force and finally becomes exhausted.

The duration of the period during which syphilis may be communicated either by direct contagion or by transmission to the offspring has most important bearings both from a medical and social standpoint. There is perhaps no subject in the entire domain of medicine of greater practical interest than the relations of syphilis with marriage. The determination of the question, When may a syphilitic man marry with safety? involves not only the protection of his wife from the risks of contagion, but also the prophylaxis of hereditary syphilis.

It becomes, then, important to inquire what is the duration of the contagious stage of syphilis. Less than a generation ago, there would have been little hesitancy in answering this question. A majority of syphilographers would have asserted that the contagious activity of syphilis begins and ends with the chancre. Ricord (in his "Lettres sur

¹ Read before the New York County Medical Society, February 28th, 1887.

la Syphilis," 1856) thus formulated the generally accepted view, "the primary ulcer in its period of extension is the only source of the syphilitic poison."

A brief historical resumé of the opinions entertained upon this point shows that the older observers considered syphilis contagious throughout all its periods. The blood, milk, saliva, sweat, semen, all the secretions were supposed to contain the virulent principle. This conception of syphilis was generally held until the time of Hunter, who, basing his conclusions upon unsuccessful attempts at reinoculation, denied that syphilis could be communicated except from the primary sore. Hunter's doctrine of the non-contagiousness of secondary accidents was adopted by Ricord and his followers and maintained with the most obstinate tenacity until about twenty-five years ago, when it was definitely abandoned.

At the present day, it is universally admitted that the blood as well as the morbid products of syphilitic lesions are, during a certain period, contagious and inoculable. But when we attempt to determine the precise time when the syphilitic organism becomes cleansed of the "foul and perilous stuff" of contagion and loses forever its capacity of reproduction, it is impossible to fix a definite limit.

The general assertion that secondary accidents are contagious, while tertiary accidents are not, is a loose statement, lacking in scientific accuracy. The modern differentiation of secondary and tertiary lesions, based upon the anatomical forms of the syphilitic process, is recognized as the only scientific basis of distinction. While in many cases syphilis is characterized by a certain definite order in the evolution of its lesions which admits of its division into stages, yet this regularity of development often fails. Superficial, secondary accidents may continue to recur for months and years after the chronological completion of the secondary stage, yet few would have the temerity to assert that late buccal syphilides, morphologically identical with mucous patches, carry with them no risks of contagion.

On the other hand, there may be a precocious development of tertiary lesions, often within a few months after the inception of the disease. Now, no one would be justified in asserting that these lesions, though distinctly of a tertiary type, occurring at a time when the blood and the entire organism is saturated with the virulent principle, are devoid of contagious activity.

Experimentation and the facts of clinical experience furnish the only sure basis for the determination of these points. Experimental attempts at inoculation have been made with the morbid products of tertiary lesions occurring at an advanced age of the diathesis, but never with gummatous or ulcerative lesions developed precociously. While suc-

cessful inoculations have been repeatedly made with the secretions of mucous patches and pustular syphilides of the secondary stage, no attempts have been made to inoculate the secretions of late papular lesions which, though secondary in form, are, from a chronological point of view, distinctly tertiary, so that the results of experimentation fail to enlighten us upon this point.

Turning now to the facts of observation, we find that clinical evidence is direct and conclusive in establishing the contagiousness of late secondary accidents. Fournier, in his work on "Syphilis and Marriage," reports the case of a medical man who married three years after contracting syphilis. Several months later he infected his wife from a minute erosive papule. He also records a case in which infection occurred from a lingual syphilide after five years, another in which a man married after four years of syphilis and after the birth of the second child infected his wife from a buccal syphilide. Still another in which a man marries after seven years of syphilis and procreates a syphilitic infant which communicated the disease to the mother in utero.

In his classic work ("Leçons sur les Maladies Vénériennes," 1883, p. 703) Mauriac reports two personal observations of late contagious lesions, one occurring at 3 years and 5 months, the other at 3 years and 3 months after the début of the disease. He further says, "there are undoubted examples of syphilitic contagion in the fifth or sixth year from individuals who still present mucous patches." The same author has recently reported (*Gazette des Hôpitaux*, April 1, 1886) two cases of syphilis conveyed by late lesions; in the first case, syphilis was communicated to the wife from a lingual lesion of the husband nine and one-half years after the début of his syphilis. In the other, the wife was infected by the husband four and one-half years after the date of his chancre. Numerous cases of this character are found scattered through medical literature. They are attested by careful and conscientious observers, after eliminating every possible source of error. To deny their authenticity is to impeach the veracity and competency of the observers.

From the standpoint of the prophylaxis of hereditary syphilis, it is no less important to inquire into the limitation of the period during which syphilis may be transmitted from the parent to the offspring. At what epoch in the evolution of the diathesis does the syphilitic organism undergo that inexplicable change which robs it of its transmissive power?

The teachings of science upon this point are by no means fixed and definite. We know certainly that time exerts a marked attenuating influence upon syphilitic heredity. As the interval between the date of infection and impregnation lengthens, there is a progressive enfeeblement

of the syphilogenic capacity, as shown in a series of successive pregnancies. After a variable time, the syphilitic taint ceases to be manifest in the offspring, and subsequent pregnancies result in healthy children exempt from all traces of syphilis. Unfortunately the accumulated facts of experience and observation furnish no positive data for a mathematical computation of the period during which hereditary transmission is possible. Kassowitz places it at from six to ten years in men, ten to fourteen in women. Weil says the usual duration is ten years; seven years is the minimum. Taylor has reported a case in which the paternal influence was manifest in the procreation of syphilitic children during ten years. Fournier has reported numerous cases of this character. Hutchinson has reported a case in which the syphilitic influence was prolonged fifteen years, resulting in eleven syphilitic children. While sex in no way modifies the duration of the contagious activity of syphilis, most authorities agree that the influence of maternal heredity is more potent and pronounced, and of much longer duration than that of paternal heredity.

In making this comparative estimate of the relative intensity and duration of paternal and maternal heredity, it may be proper to refer to the fact that some syphilographers contend that hereditary syphilis is derived exclusively from the mother. A glance at the literature of the subject shows that the doctrine of the paternal transmission of syphilis, first formulated by Paracelsus, has always been generally accepted, with few notable exceptions. Hunter was one of its most conspicuous opponents, as it conflicted with his dictum that the primary sore was the only source of the contagion.

Cullerier (in 1851), basing his conclusions upon his observation that syphilitic fathers sometimes procreated healthy children, denied the possibility of paternal agency in the transmission of syphilis. His theory, *pas de syphilis de l'enfant sans syphilis de la mère* for a while found many advocates, but the overwhelming mass of clinical testimony brought to bear against it has convinced the most skeptical, and to-day there are few partisans of this theory.

We may briefly refer to a few of the statistics bearing upon this point. Of 119 families carefully observed during a number of years by Kassowitz,¹ in 43 of the families the fathers were syphilitic and the mothers showed absolutely no symptoms. The statistics of Mewes, of Dresden, contain observations of 109 syphilitic children born of 108 mothers in whom no sign of syphilis could be found. Anton, of Berlin, reports 70 births of syphilitic children, the mothers of 15 being certainly free from syphilis.

¹ Kassowitz, *Jahrbuch für Kindhklde.*, xxi. B., 1 u. 2 H. *Am. Jour. of Obstetrics*, July, 1884.

Hecker, of Munich, reports 53 cases where the mothers of syphilitic children showed absolutely no symptoms. Fournier reports over 50 pregnancies terminating in abortion, death in utero, or syphilitic children, where the mothers were entirely exempt from all signs of syphilis. These statistics could be fortified by individual observations of the most reputable authorities, many of whom have reported series of cases occurring in private practice, where syphilitic fathers have procreated children undoubtedly syphilitic, while the mothers, carefully and frequently examined for months and years, have remained absolutely exempt from the slightest manifestation of the disease. Either we must grant the existence of a symptomless syphilis, *une syphilis imperceptible*, or admit the fact of paternal heredity.

Convincing proof that women may bear syphilitic children without preliminary infection is found in the many well-attested examples of mothers contracting the disease while nursing their own syphilitic children. Cases of this character have been recorded by Guibout, Cazenave, Lueth, Ranke, Scarenzio, and others cited by Kassowitz. Further proof is found in the fact that women who have borne syphilitic children from a syphilitic man, bear healthy children from a healthy husband.

It would seem hardly necessary to bring forward clinical facts and arguments in support of a theory which is to-day almost universally admitted, were it not that, in an elaborate paper,¹ presented last year, its distinguished author denied the possibility of paternal influence in the transmission of syphilis. In his paper on the "Limitation of the Contagious Stage of Syphilis, especially in Relation to Marriage," my esteemed friend, Dr. Otis, advanced certain views which are not only at variance with those generally held, but are diametrically opposed to the facts of clinical experience. These views, if accepted, would, in my opinion, have a tendency to break down the barriers which enlightened prudence and a wise conservatism have erected as a safeguard against the introduction of syphilis into marriage.

Briefly analyzed, Dr. Otis' paper contains an elaborate exposition of his theory of the physiology of syphilitic infection, and, as a logical sequence of this theory, his conclusions as to the local nature of the primary sore, the relatively short duration of the contagious stage and the impossibility of the paternal transmission of syphilis. The first objection which would suggest itself is that he draws certain definite conclusions, without reference to the fact that there are many objections to the correctness of the theory which would necessarily invalidate his conclusions. It is not my purpose to discuss the germinal-

¹ JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, March and April, 1886.

cell theory of syphilitic infection, since the points at issue cannot be determined by any appeal to a mere theory, no matter how ingeniously conceived or skilfully elaborated; they can only be settled by a careful study of clinical facts.

Since, as Dr. Otis affirms, syphilis is never under any conceivable circumstances communicated by the father without preliminary infection of the mother, the duration of the contagious stage of syphilis must be regarded as the exact measure of the period during which a syphilitic man can by any possibility endanger his wife or offspring. The dangers which a syphilitic man introduces into marriage are thus narrowed down to the contagious accidents which he may bear upon his person. After three years of infection these accidents, according to Dr. Otis, do not contain the contagious property of syphilis and hence cannot communicate it. He says, moreover, I have *never* seen a case of syphilis presenting an undoubted lesion of the secondary active stage after the termination of the second year.

It is this fatal facility of deduction, I would respectfully submit, which has been the foundation of many serious errors that have impeded the progress of medicine. Ricord never saw syphilis communicated by secondary accidents, and thus an unfortunate error, defended by the weight of his high authority, was perpetuated almost to the present day. Cullerier and others never saw syphilitic children procreated by a syphilitic father, and upon this negative observation was based a doctrine eminently dangerous from a social point of view.

Opposed to this negative testimony of Dr. Otis as to the development of contagious lesions after the termination of the second year, we have the positive testimony of numerous observers who have recorded cases of infection from syphilis in the fourth, fifth, sixth year and even later. The high reputation of the observers affords every guarantee of the authenticity of these cases of infection from late lesions; they cannot, therefore, be rejected on the ground of erroneous observation.

Finally Fournier's statistics of 87 syphilitic men who had married, had never infected their wives, and had begotten 156 absolutely healthy children, are brought forward to demonstrate the non-contagiousness of late accidents and the non-influence of paternal heredity.

In presenting these statistics, Fournier expressly warns "any one against exaggerating their importance or attaching to them a significance of which they do not admit."

There is nothing more misleading than a wrong interpretation of clinical facts. If these statistics establish the non-contagiousness of late accidents, an equally legitimate conclusion would be that early secondary accidents are not contagious, since ten per cent were married

within two years after infection, one immediately after cicatrization of the chancre, one at twelve months, another at fourteen months, still another at nineteen months.

When we come to examine these cases more closely, we find that 67 of these patients married after the 4th year, 49 of them after the 5th year, as follows: 11 after 5 years, 10 after 6 years, 4 after 7 years, 8 after 8 years, 6 after 9 years, 2 after 10 years, 4 after 11 years, 1 after 12 years, 1 after 13 years, 1 after 14 years, and 1 after 15 years of syphilis. It will thus be seen that the large proportion of these cases have no possible bearing upon the point at issue, since marriage took place after a period when all authorities agree that the syphilogenic capacity is minimized or reduced to nil.

It is hardly consistent to accept Fournier's negative testimony as affording absolute proof of a proposition, while rejecting his positive statistics, equally trustworthy, which establish not only the possibility, but the prolonged duration of the paternal influence in the transmission of syphilis. Thus Dr. Otis ignores Fournier's personal observations of 14 syphilitic men who married and never communicated the disease to their wives, and yet these marriages resulted in 58 pregnancies; 50 of which terminated in abortions or in syphilitic children, stillborn, moribund, or dying shortly after birth, and 8 only in healthy children. And yet the average date of these marriages was after $4\frac{1}{2}$ years of syphilis.

It would be easy to multiply statistics of a similar character from other competent and careful observers, testifying not only to the fact, but to the occasional prolonged persistence of the paternal hereditary influence. Enough have, however, been adduced to show that the position of Dr. Otis is opposed by an overwhelming mass of clinical testimony. This verdict of enlightened experience has been accepted by all leading text-writers on general medicine, on obstetrics and pediatrics, as well as by syphilographers, and to-day there is an almost complete unanimity of sentiment upon the doctrine of the paternal transmission of syphilis.

If time permitted, it would be interesting to study other phases of this subject: the transmission of syphilis by conception, the influence of specific treatment in suppressing or temporarily holding in abeyance the syphilogenic capacity, the modification which it naturally undergoes during periods of latency or activity of the diathesis, etc.

From this brief survey of the subject we may formulate the following conclusions:

1. The facts of every-day observation show that there is nothing constant in contagion, nothing certain in heredity. Many men marry with a syphilis in full activity of secondary manifestation and never infect their wives or transmit the disease to their offspring. These negative

observations are, however, entirely valueless as a basis for estimating positive results.

2. The modern division of syphilis into secondary and tertiary periods, based upon anatomical forms and processes, does not furnish a safe criterion for determining the contagious or non-contagious character of the lesions.

3. The chronological completion of the secondary stage does not always mark the definite disappearance of the virulent principle; clinical experience shows that late lesions are exceptionally, but none the less certainly, the source of contagion.

4. While in the immense majority of cases the contagious activity of syphilis and its susceptibility of hereditary transmission cease after the third or fourth year, yet well-authenticated observations prove in the most positive manner that these qualities sometimes continue in force much longer and may be manifest in the fifth and sixth year of the disease, and even later.

5. The aptitude of syphilitic parents to procreate diseased children may persist after the cessation of all specific manifestations; the contagious stage of syphilis is not, therefore, the exact measure of the duration of hereditary influence.

6. The precise date in the evolution of the diathesis when the syphilitic organism undergoes that radical transformation which marks the limit of its contagious or transmissive power does not admit of mathematical expression.

7. It is probable that this limit varies in different cases and that many circumstances contribute to advance or defer it.

8. The type of the syphilis, the constitutional peculiarities of the patient, the character of the treatment, the presence or absence of certain conditions which are recognized as factors of gravity in syphilis, all exert a modifying influence.

9. All these elements should be taken into consideration in deciding upon the admissibility of a syphilitic man to marriage; each case should be studied upon its individual merits.

10. The direct paternal transmission of syphilis, without preliminary infection of the mother, may be classed among the most conclusively established facts of medical science.

11. It is, therefore, a dangerous doctrine to teach that the sole risks a syphilitic man introduces into marriage consist in the contagious accidents he may bear upon his person.

12. The arbitrary designation of a limit of three, or at most four years, as perfectly safe for a syphilitic man to marry, with or without treatment

and irrespective of the actual existence of specific lesions, is unwarranted by science or the teachings of experience.

The conditions of admissibility to marriage formulated by Fournier are much broader, more scientific, more safe. These demand a mild or medium type of the disease, an advanced age of the diathesis, three or four years at the minimum, and a prolonged immunity, eighteen months to two years, from specific accidents; if these guarantees of safety are further fortified by sufficient specific treatment, a reluctant consent is given; marriage is tolerated rather than advised.

IN THE DISCUSSION OF DR. MORROW'S PAPER,

DR. OTIS replied: The number and magnitude of the questions raised in Dr. Morrow's elaborate paper renders the task of considering any one of them thoroughly in the brief space that can be allotted during a discussion like the present simply impossible. But little more can be done than to enumerate the points upon which I take distinct issue with Dr. Morrow, and to reply to the statements which he has made, evidently with the intention of controverting the argument which I made in a paper read before the State Medical Society a little more than a year ago, and which was intended to show a possible limitation of the contagious stage of syphilis to three or four years.

In the first place, I would deny that, as stated by Dr. Morrow, superficial secondary accidents may continue to recur for months or years after the chronological completion of the secondary stage with all the contagious property of that stage, and would claim that syphilis, as usually understood, is clearly divided into two distinct stages: One, the active, including the so-called primary and the secondary stage, in which a contagium has been proved, claimed always to be present, and equally shown to lose the contagious property within a few years—exact time not definitely fixed, but approximation to which may, it is believed, through careful clinical observation be more nearly arrived at than is generally accepted at present.

Second, the so-called tertiary stage of syphilis, wholly differing from the active or secondary stage: first, in that it lacks the contagious element of syphilis; and second, that this stage is always, and of necessity but a sequel of the active stage, and that stages of the disease cannot be transposed in any case so that the tertiary shall precede the secondary any more than that the fruit of a plant shall precede the flower. There are, it is true, so-called precocious syphilides where an ulcerative eruption presents, which simulates the so-called impetiginous tertiary eruption, developed in place of the typical papular eruption, where superficial ulcers, as large perhaps as one's hand, may be present, but such eruptions yield to mercury and not to iodide of potassium, and are never of the depth or gravity of true tertiary lesions. The late lesions are again clearly distinguished by the presence of the so-called gummy material or its derivatives, while these have never yet been found associated with the typical secondary manifestations.

It is not denied that lesions, especially of the tongue and papular

eruptions, may sometimes be difficult to place either in the active or the late stage; when proven contagious they belong to the former, when they are not contagious, the latter. I claim that they have not yet been proven contagious after the third year. I have published several carefully observed cases when such lesions simulating contagious lesions in some respects were proven free from contagion by marriage and the birth of healthy children, and recurrences of trouble after this. I have never advised marriage when such lesions were present, but have consented to marriage in their absence after three years of treatment, and then seen them recur without infection of wife or child.

I have seen and reported ulcerations of the tongue simulating mucous patches recurring five and six years after infection, when marriage has taken place, and no infection of wife, and healthy children born; and further recurrences of so-called mucous patches and yet no contagion; child in one case now four years old. I placed this case against a similar one cited by M. Fournier, where a labial chancre was said to have been acquired from such lesion five years old by the mistress of the patient. In my case, the contact was with a virtuous woman, and no syphilis followed. I claimed that the labial chancre in M. Fournier's case was from another source, the possibility of which, notwithstanding the character of the woman, was not even suggested by M. Fournier; and this case was the only one cited by Fournier, in full, as showing the possible persistence of the contagious property for many years, and in contradiction of his experience in a very large number of well-observed cases. Now this experience of M. Fournier covers a prolonged observation of 330 individuals; 87 fathers, 87 mothers, and 156 children. It is cited in full by M. Fournier, at pages 13 and 97 of his book on "Syphilis and Marriage" (Am. Ed.), as follows: "For my part, I have in hand (to speak only of recorded facts) 87 observations relative to syphilitic subjects, undoubtedly syphilitic, who having married, have never communicated to their wives the least suspicious phenomenon: and what is more, have begotten, these 87, a total of 156 children absolutely healthy." Further he says: "These observations, which I have chosen among many others, all relate to patients and to families that I have scrupulously examined and followed up, and that I have had under observation for many years, many of whom are still in close relations with me." This statement is twice repeated, in full, at page 13 and also at page 197, where the statistics of these cases are given in detail. In carefully examining these statistics, I found that 36 out of this number of men who were thus proven to be free from any power to transmit syphilis by direct and intimate contact, or by heredity, were subjects of late or tertiary lesions after marriage—some before and some after the birth of children. Almost all the typical varieties of late lesion and in every grade of severity were included. In examining the statistics of M. Fournier still further, it was found that the average time of marriage after infection in the 87 cases was $5\frac{8}{10}$ years; that over $22\frac{1}{2}$ per cent were married at three years or under; $43\frac{1}{2}$ per cent were married at four years or under; and over 9 per cent two years or under. I would then here claim, as I have done in my paper read before the State Medical Society, that in view of this enormous mass of evidence, consisting of 87 authentic examples involving prolonged observations of 330 individuals adduced

by an acute, thorough, and conscientious observer, as well as from the general experience of certain able and recognized authorities, and some carefully recorded experiences of my own, that wherever syphilis has been apparently communicated or has been claimed to have been communicated by a person whose syphilis dated back more than three or four years to time of acquirement, that such case, if submitted to thorough expert scrutiny, would be shown to have been erroneously so claimed, and that the true source of the disease, supposed to be so communicated, was from a lesion either on the person suspected or from some other source, less than three years old.¹

I believe that it can be satisfactorily proven that beyond the so-called secondary period of syphilis, there is no contagious property inhering in the person the previous subject of syphilis, and that all the lesions of the so-called tertiary stage of syphilis of whatever character, are free from the contagious element, are not therefore syphilis strictly speaking, but the sequelæ of that disease; and that the limitation of the disease proper, in its relation to marriage, may certainly be placed at the termination of the so-called secondary period of syphilis, at whatever time that may occur.

1. This point has been practically determined through the experience of the profession throughout the world, and reflected in the teachings of all authorities on syphilis, who enunciate it unmistakably when they fix the period and take the responsibility of authorizing a man who has once had syphilis to marry.

This period is fixed practically at from three to four years from the date of infection. Of our own authorities, Bumstead and Taylor say: "It may be stated in broad terms that no syphilitic father should procreate children until two years after infection, during which he should sedulously follow a systematic course of treatment."

Keyes ("Venereal Diseases," Wood & Co., 1880) says: "After the virulence of the disease has been exhausted, a man may marry, and should marry." Again, page 78, *ibid.*, "In a general way it may be safely said that a man should not marry until at least three good years lie between him and his chancre, and at least one year has elapsed since the last symptom which can be ascribed to syphilis."

M. Fournier, in his recent work on "Syphilis and Marriage," says: "Three or four years is the minimum, the necessary, indispensable minimum, in order that the diathesis may be weakened by time and treatment, that the patient restored to ordinary conditions may properly aspire to become husband, father—head of a family."

2. Practically, then, it is acknowledged that under the proviso of a thorough treatment of from three to four years, the point we are seeking is fixed, as before stated. But there is another proviso made by all, *viz.*, that there shall be, after this thorough and prolonged treatment, an interval of from one to one and a half years, during which, without treatment,

¹ I am indebted to Dr. Morrow, who is the American translator of Fournier's work on "Syphilis and Marriage," since the reading of my paper before the State Society, for a slight correction of my statistics. I then stated that 25 per cent were married within three years; he showed me that it was only 22 $\frac{2}{3}$ %; and within two years only 9 $\frac{1}{2}$ per cent instead of 10. I found this to be the precise ratio on consulting the original; also I found that over 43 per cent were married within four years.

no syphilitic manifestation shall have appeared. Now it is well understood that in a man who has once had syphilis, a so-called syphilitic manifestation may appear at any time after apparent cure during the next fifty years. If it comes before a man marries, he cannot marry; if afterwards, what then? He may have fulfilled all the most rigid conditions of Mons. Fournier's requirements, and yet we all know he is liable, or it is possible for him to have a subsequent tertiary lesion. We cannot then be justified in allowing any one to marry who has once had syphilis, unless we can determine that there is a limit to the contagious stage of syphilis, unless, in other words, we can show conclusively that the lesions of tertiary syphilis are not true syphilis, but its sequelæ, and then prove that these sequelæ are purely personal matters, not capable of being transmitted by contagion or by heredity.

Practically, when we advise or tolerate marriage in syphilis within three or four years, we admit that this is the end of syphilis as a contagious disease. Otherwise it would be monstrous to advise or abet such marriage in any case, because no case is ever quite free—no matter how treated—from the danger of subsequent manifestations of the late or so-called tertiary forms. We must then, if we would ever be justified in advising or consenting to such marriages, be able to draw a clear line between true syphilis and its sequelæ, and be certain that the latter are not capable of transmitting disease, or we make ourselves responsible for an acknowledged risk of being a party to the communication of syphilis to innocent persons.

Some authorities practically claim that, if marriage is ever permitted, this risk must be taken. Hill and Cooper, of London, 1881, say that under no circumstances should a person with obvious signs of syphilitic disease marry, however long a time has elapsed since his infection, for though communication is rare when several years have elapsed, it may still take place as many as ten or even more years, *even when the form of the disease is of the character called tertiary*. Even Fournier claims an exceptional syphilitic diathesis which may communicate syphilis which lasts indefinitely. But the sole example which he cites especially to prove this may be reasonably shown to have belonged to the tertiary period, and it is more than probable that the contagion claimed from such lesion was due to an entirely different source. It is a significant fact that not only in this case, but in all the cases I have met when syphilis has been claimed to be due to a lesion acquired more than three years after infection, no mention has been made of the possibility of its acquirement from an independent source or through mediate contagion.

The overwhelming evidence as to the improbabilities of the communication of syphilis after the first three or four years from the date of infection, as shown by the statistics of M. Fournier, should lead to the greatest opposition in accepting cases alleged, where syphilis has been acquired in contradiction of this position.

"The traditions of syphilis claim that once a man has had syphilis he is a possible focus of contagion forever, and any evidence that a man has once had syphilis is held as competent to prove that any syphilitic accident in his family, to the latest generation, may be reasonably credited to him. The important fact that syphilis may be communicated through other sources is practically ignored. Syphilis from

mediate contagion is common. It may be through the medium of a spoon, a pencil, a cane, a cigar, a kiss, the dentist's instruments. The accoucheur may acquire it through his finger. Nine cases of syphilis of the finger I published several years since as occurring under my own observation, and I have seen others since that time. Besides this, I have seen at least double that number of cases of syphilis where no possible trace of the source of contagion could be ascertained. A tumbler, or any article in common use, defiled with the secretions of a mouth harboring a mucous patch, coming in contact with a crack or abrasion of the lips of a healthy person, may communicate syphilis through a resulting lesion which may pass away unnoticed. Any similar contact with the blood of a person in the active stage of syphilis will communicate it. And yet, if the resulting syphilis is not distinctly traced to some one of these sources, the disease is possibly attributed to some innocent person who has had syphilis perhaps a quarter of a century before."

Dr. Morrow, with apparent cogency, claims that, in my paper before the State Society, I presented Fournier's statistics in proof of my position, ignoring wholly fourteen cases of Fournier's personal observations which went to prove the prolonged duration of the paternal influence on the transmission of syphilis. In answer, I would say that nothing in my judgment, except proof of imperfect observation, could take away from the force of such statistics as I cited. The cases alluded to by Dr. Morrow are not distinctly presented by M. Fournier as drawn from his own personal observations. They appear as a note (Note VII.) at the end of his volume, under the head of "Inaptitude for Life, as an Hereditary Consequence of Paternal Syphilis." He says: "I cannot reproduce here all the facts which have served to establish my conviction upon this point; but I think I ought to place a certain number under the eye of the reader as illustrative cases." He does not say, as when presenting the 87 cases which I cited to prove my position—"To speak only of recorded facts, etc., . . . that I have scrupulously examined and followed up," etc., etc. On the contrary, he puts them in a note at the end of his book in such a way as to show that they are not wholly his own, but cases which illustrate the possible hereditary consequence of paternal syphilis. When besides this he quotes Mr. Hutchinson, of London, 1876, page 39, as supporting the paternal heredity, and as saying, "I am firmly of the opinion that in a large majority of instances in English practice, inheritance of syphilis is from the father, the mother never having suffered before conception." And now we refer to Mr. Hutchinson's present position taken in his "Pedigree of Disease," 1882, where, page 90, he says, "A child then, I assert, inherits syphilis in precisely the same sense and in precisely the same manner as it may inherit small-pox. *It inherits not the diathesis, but the disease.*" We may then reasonably hesitate before accepting the sort of evidence which is afforded by the fourteen cases referred to by Dr. Morrow, observed, we are not informed when or by whom, and evidently put in as a conscientious afterthought by M. Fournier, to show what some observers have claimed.

In regard to infection of the infant by the father, the mother wholly escaping, Dr. Morrow says that "convincing proof that women may bear syphilitic children without preliminary infection is found in many well-attested examples of mothers contracting the disease while nursing

their own syphilitic children." Nevertheless, Fournier says, page 191 (Morrow's trans.): "Never does one encounter a case, however plausible the theory may be, of a mother nursing her own syphilitic child and contracting syphilis from it." In a note on same page in this connection he also quotes Colles' law thus: "It is a curious fact that I have never witnessed nor ever heard of an instance in which a child deriving the infection of syphilis from its parents, has caused an ulceration of the breast of its mother." Fournier then says: "I am aware that many cases have been cited in opposition to this law . . . what the cases in question are worth, I cannot say, for my part *I have never encountered similar ones*, at least up to the present time." (Ital. my own, F. N. O.) At page 244 (note VI.) Fournier quotes a case of Dr. A. Charrier in full which seems in the most striking manner to explain the true situation in such cases. In brief, child syphilitic, mother apparently healthy. Dr. Charrier a strong believer in the impossibility of child being infected except through the influence of the mother. The mother critically watched by him for six years without detecting a sign of syphilis. "This fact," he says, "overturned all my belief in syphilitic heredity and notably my cardinal conviction that if a child be born tainted with syphilis, the mother must certainly have been infected." Then at the end of six years of observation he was just about to publish it, recanting former opinions, when the lady came to him with a well-marked gummy tumor of the arm. He concludes his narration thus: "Altogether this case, which seemed at first as if it must of necessity overturn the theory which I had for a long time sustained (in accord with M. Cullerrier, M. Notta, and other observers), viz., that every syphilitic child is born from a syphilitic mother—this case, I say, has, on the contrary, furnished an additional argument for the theory in question and confirms it absolutely."

In point of fact, such cases are not, I think, as common as one would be led to fear by Dr. Morrow's statistics.

Fournier says (page 38 of Dr. Morrow's translation): "We have seen that children are born syphilitic through the agency of their father, their mother remaining exempt from all contamination." He then cites various authors who confirm this, and then he says, "I myself have observed some cases, although relatively few, I confess," and in a note he says, "I find in my notes eight of this kind; even some of these I admit *are wanting in the guarantee of authenticity* (italics mine) which would be required in a matter so delicate and so disputed." He does not tell us how many had that guarantee. We are led to suggest in this connection that it is claimed by all the recent authorities, Fournier included, that the physiological secretions, the tears, the sweat, mucus, sebum, milk, urine, *semen*, etc., *do not contain the contagium of syphilis*. If this be the fact, it has not yet been explained how the male has access to the ovum or infant except through first infecting the mother. Hutchinson has told us that the disease and not the diathesis is inherited, in other words, that there is no such thing as the paternal heredity of syphilis. Nevertheless, Dr. Morrow tells us in his summing up that "the direct paternal transmission of syphilis without preliminary infection of the mother may be classed among the most conclusively established facts of medical science."

I fully coincide with Dr. Morrow in claiming that "it is a dangerous doctrine to teach that the sole risks a syphilitic man introduces into marriage consist in the contagious accidents he may bear upon his person." All intelligent physicians now understand that the blood, as well as the secretions of lesions of secondary stage, are contagious, and that the syphilitic may infect his wife without himself bearing a secondary lesion; a scratch during coition may effect an inoculation of the wife at any time during the active stage of syphilis, independent of any external syphilitic manifestations, and then come the after-risks through a husband incapacitated or disfigured with a tertiary lesion; these possibilities are never to be forgotten or understated when it becomes the duty of the physician to advise in such matters.

The arbitrary designation of a limit of three or at most four years as perfectly safe for a syphilitic man to marry, with or without treatment, and irrespective of the actual existence of specific lesions, Dr. Morrow states is unwarranted by science or the teachings of experience. Inasmuch as I have never designated such a limit as safe or advised persons to marry under such circumstances, I can only account for this position, which is thus broadly condemned, by answering that Dr. Morrow has misunderstood the object and scope of my State Society paper. Its avowed object was to discuss the possibility of arriving, if possible, at some definite limitation of the contagious stage of syphilis through a careful analysis and discussion of facts which could be gathered bearing on this point. My own conviction was strongly expressed, as in view of my own experience and the other evidence I could reach—that this stage did not last more than three years instead of many years and possibly for a lifetime as claimed by some. Marriage I did not advise, and do not until after a thorough treatment of two to three years and an immunity from subsequent lesions for a year longer at least, and not then if any lesions of the tertiary stage are present. Nevertheless, the evidence I have been able to gather has convinced me of the practical termination of the contagious stage of the disease in three years. This, I think, we may hope, through more extended and careful observation on this point, will be proven to cover the life of the contagium of syphilis.

DR. R. W. TAYLOR.—Mr. President, there has been so much brought up in this excellent paper by Dr. Morrow that to discuss it fully would require too much time; I will, therefore, confine my remarks to a few of the main points. These are, first, the duration of the contagious stage of syphilis; second, can there be made an arbitrary division of syphilis, as the older writers claim, into secondary and tertiary; and, if we make this arbitrary division or line, are we able to say that in the second stage the disease is contagious, and in the tertiary it is not contagious? Third, the course of syphilis, and its contagious character as bearing upon marriage.

I think the keynote of the contagiousness of syphilis can be stated in one word, treatment. If a case of syphilis is taken early, and treated from the beginning of the secondary manifestations for two years, in the great majority its contagious character will disappear within that period or within two years and a half. This I have observed very many times, and I think it can be stated as a rule that syphilis in a healthy or tolerably healthy person, treated carefully for two years, will be no longer

contagious, and in the majority of cases such a man or woman—man particularly—can procreate healthy children.

But unfortunately we cannot make all patients submit to systematic treatment, hence we have this long-continued contagion, these periods of latency and of activity. Clinical experience shows that lesions, the secretions of which are contagious, sometimes occur late. For instance, the occurrence of a papular syphilide may be as late as the fifth or sixth year. Only last week I had such a case in my office. It was in a patient who had not undergone treatment. I wonder what syphilologist would be willing to have this patch scraped, and be inoculated with the débris of it. Certainly I would not. Such are, however, rather exceptional cases, showing how the secondary lesions may be prolonged into the so-called tertiary period, and we cannot be assured just what length of time the secondary stage will continue. No law can be laid down on this subject, and I do not believe that a law can ever be made defining with mathematical certainty just when syphilis will cease to be contagious. I mean syphilis uninfluenced by treatment. That this disease does gradually wear itself out we know, and that then the patient ceases to have syphilogenic power is shown by two facts: A man or woman having tertiary lesions upon them may procreate healthy children. Certainly no syphilologist of any experience will deny that fact. I can recall many instances of it. Another even more positive fact showing that tertiary lesions have ceased to possess any contagious power is this: You will find cases of undoubted reinfection with syphilis beginning with the initial lesion, and running a typical course, in whom tertiary lesions such as ulcerating gummata, nodes, buccal and lingual epithelial hyperplasia and periosteal thickening yet exist as evidences of a former and now extinct infection.

As to the duration of the contagious stage, each case must be studied by itself, and while I think that as a rule in treated cases two years and a half to three years ends the period of contagiousness, yet all these provisos must be taken into consideration—the health of the patient, his disease having yielded to treatment, having continued treatment for a long time, there being no cachexia nor indications of it; when these conditions have been complied with, I think the contagious stage has passed.

The question then arises, what course shall we pursue with syphilistics in relation to marriage? Now, marriage as it is treated of in the books is one thing, while marriage as it is talked of to us in the consulting room is another. It is not a question in many cases of, shall I get married? It is stated differently: I am going to get married; certain reasons have forced upon the patient matrimony. Now the books may tell us, give the patient five years before allowing him to marry; others may say a shorter time. But certain family reasons have forced upon this man marriage at the earliest possible date. The duty lies with you to say how soon marriage is at all permissible. I never give consent under two years, and I do not give it then unless the man has intelligently and persistently followed my treatment during that time, and if I can, I then try to get six months more. That is, in the cases where marriage is imperative. But I have seen men with syphilis of a severe form get married within six months, and not contaminate their wives, and for

he reason that I have given them every possible precaution as regards contagion from the penis, from mucous patches, and from the blood. Then I say to those men, do not allow your wife to become pregnant, for if you do, the chances are that you will have a macerated fœtus or a blemished child as a result, and I tell them to resort to certain expedients in the way of copious vaginal injections, to prevent conception until such a period as the contagious principle shall have ceased. I know religious people will say, that is not right. But religious people generally are not intelligent sanitarians, and I think it is a duty of the physician to be an intelligent sanitarian.

Going along to the second year, or two years and a half, I can recall many men and women who have passed through syphilis, and procreated children year after year, in whom no blemish has appeared.

DR. BRONSON.—Mr. President, there is nothing in medicine more uncertain than the prognosis of syphilis, and there are few occasions where an accurate prognosis of the disease would be more desirable than in the case of an individual contemplating marriage. There are two factors to be especially considered in this connection. First, the duration of the syphilitic diathesis; and, second, certain modifying conditions pertaining more particularly to the individual affected. As to the duration of syphilis, it is extremely difficult to establish any rule. No two cases run the same course, and it is impossible to predict beforehand how long the virulence of the disease will last or when the power of communicating it to others or of transmitting it to the offspring will cease. I do not believe that because an individual has ceased to show outward signs of the disease, the virus is necessarily extinct. We see too many instances where persons, after long periods of exemption from syphilitic manifestations, have suddenly developed symptoms of the disease. Moreover, persons who have had syphilis may procreate healthy children, and afterwards, without fresh infection on the part of the parent, other children may be born bearing evidences of the disease. These facts indicate indefinite periods of latency of the syphilitic virulence which render the prognosis exceedingly uncertain.

There is without doubt, however, a gradual diminution of the syphilitic poison. We see that in the varying reaction of syphilitic products at different periods of the disease. While the matters from the initial lesion and mucous patches are highly contagious, those from pustules and ulcers of a later stage are less so, the syphilitic blood still less, while secretions from the gummy tumor have, if any, too little of the virus to be infectious. The attenuation doubtless goes on till the tissues cease to contain or develop any of the contagious principle.

With regard to the influence of paternity and maternity in hereditary syphilis, I agree in the main with the conclusions of the writer of the paper, but there are certain details to which I would take exception. The influence of the father is unquestionable, and there is no question that syphilitic fathers do beget syphilitic children without the mothers showing obvious signs of the disease. But I am unwilling to admit that syphilis may not exist without obvious manifestations. I think we have incontestable evidence of the fact that the mothers of syphilitic children do acquire the disease, in the fact of their subsequent immunity from infection. There are doubtless certain persons who are refractory to

syphilitic contagion, but there is no general class of persons enjoying invariable immunity from the disease except those who have had it before and those mothers who bear syphilitic children. The so-called Colles' law is well known, viz., a mother who has given birth to a syphilitic child, although she may show no sign of syphilis, will always nurse her child with impunity, while another nurse suckling the child would be liable to contract the disease. The mother's syphilis is a modified syphilis differing from that which is acquired in the usual way; but that it is syphilis, it seems to me, is sufficiently evidenced by the fact of her immunity and also in that there are often present signs of the disease which are more or less positive, such as cachexia, or, occasionally, a palmar psoriasis.

With regard to the special conditions that pertain to individual cases, I cannot regard those which depend upon treatment as having that same degree of importance which is attached to them by some of the speakers before me. Dr. Otis has referred to the interruptions in treatment practised by Fournier. But, if I mistake not, Fournier interrupts the treatment only for periods of a few weeks in the course of a year. Fournier's views on the treatment of syphilis have undergone several changes.

First, adopting Ricord's position, a six months' course with mercury, followed by three months of iodide of potassium, were deemed sufficient. Later, two years was announced as the requisite period of treatment, and last of all, from three to four years. Some of his followers have still further extended the time; Martineau even making it continuous for a lifetime. To those holding the views that mercury is to the virus of syphilis an absolute antidote, and also that the long-continued administration of it is a matter of indifference or even tonic to the healthy organism, this last position of Martineau would appear to be the most logical of all. Not sharing these views, I regard mercurial treatment in syphilis rather as a necessary evil, and am by no means disposed to attach that degree of importance to its duration with respect to the prognosis of syphilis which it has received in the teachings of Fournier.

DR. MORROW.—Mr. President, in closing the discussion, I may say that the two points in Dr. Otis' paper presented before the State Society, upon which I took issue with him, were: 1st, the arbitrary fixation of a period of three years as marking the definite end of the contagious stage of syphilis in all cases; and 2d, the denial of the possibility of the paternal transmission of the disease.

As regards their bearing upon the admissibility of a syphilitic man to marriage, if I have understood his paper aright, it is perfectly safe for a syphilitic man to marry after three, or at most four years, with or without treatment. I do not think that Dr. Otis is in accord with leading authorities in this conclusion. Certainly, if a man cannot endanger his offspring except by infection of his wife, and he cannot possibly infect his wife after the third year, it would seem to be a refinement of caution to defer marriage after the termination of this period.

These questions, it must be admitted, can only be settled by careful clinical observation. I have brought forward a number of clinical examples, proving in the most positive manner that lesions occurring after the third year are sometimes the source of contagion. The high reputation of the authorities I have cited affords every guarantee of their authenticity.

As regards the direct paternal transmission of syphilis, I can only repeat what I have said, that this method of infection is proven by the most convincing clinical testimony, and to-day it is almost universally admitted. Kassowitz, the highest authority upon the inheritance and transmission of syphilis, says in the paper already quoted from, "within the last eight years the only authors of note who have opposed this theory are Lewin, Sturgis, Flindt, Wolff, and Roth."

As regards the "present position" of Hutchinson upon this question, it is well known that he is, and always has been, the staunchest advocate of the doctrine of the direct paternal transmission of syphilis; indeed, he has gone further than most others in attributing a greater influence to paternal than maternal heredity. In his latest utterance upon this subject (Lettsomian Lectures, *Brit. Medical Journal*, 1886, p. 239) he says: "Almost every one, I believe, now accepts the doctrine that a tainted father may beget tainted offspring." Again, same page, "the proof is overwhelming that the father can give the syphilitic virus to his child, etc."

Dr. Otis still insists upon interpreting Fournier's statistics as furnishing absolute proof of his own position. This astute observer, however, puts an entirely different construction upon them. He says (p. 38), "To enunciate such propositions" (the non-influence of paternal heredity) "you must look only upon one side of the question, you must regard only one element of the problem; for there is a vast difference between the conclusions at which you have arrived and those which are derived from an integral observation of the clinical facts."

I can only attribute to hasty reading the attempt to weaken the force of Fournier's positive proof, not only of the fact, but of the prolonged duration of the paternal syphilogenic influence, by the statement that the fourteen cases quoted in my paper "are put in a note at the end of the book, in such a way as to show that they are not wholly his own, but cases which illustrate the possible hereditary consequences of paternal syphilis." Every reader of the book must see that these cases occupy the same position as the eighty-seven cases quoted with so much respect by Dr. Otis to prove his position. These last also appear at the end of the volume among the "Notes and Illustrative Cases." The following quotation must convince anyone that Dr. Otis is mistaken in his inference that these cases, relating to fifty syphilitic pregnancies, the father syphilitic, the mother remaining healthy, "are evidently put in as a conscientious afterthought by M. Fournier, to show what some observers have claimed." Under the head of "Inaptitude for life, revealing itself by the early death of the fœtus, either *in utero* or very shortly after birth," he says (p. 41), "Formerly I was struck with the frequency of abortions in families where the husband was infected with syphilis, while the wife remained perfectly healthy. Afterward I determined to confirm this general impression by instituting a precise inquiry into the matter. With this view, I applied myself to note the results of the union of a syphilitic man with a healthy woman in a very exact manner in all the cases which came under my observation. Now, after several years of investigation in this direction, an abstract of my observations furnishes me with no fewer than fifty abortions occurring under the above-mentioned conditions, and produced without other possible cause to be alleged than the paternal dia-

thesis. And be pleased to note (it is essential to specify this) that the elements of these statistics have been collected in private practice. . . . The abortion remains inexplicable upon the assumption of influences, predisposing or determinant, to which it is usually attributable, while on the contrary, a common etiological element reunites all these cases, and serves as a common explanation for them, viz., the *syphilis of the husband*. Is not this well adapted to enforce conviction?"

Fournier's eight cases (foot-note, p. 39) quoted by Dr. Otis refer to syphilitic children. He explains the rarity of children being born syphilitic and surviving by the fact that "the syphilis of the father kills the *fœtus in utero*; it dies before being born."

Finally, I may say, that I have given an accurate analysis of Fournier's statistics; any one can calculate the percentage of marriages in the different years and draw his own conclusions as to their bearing upon the questions involved in this discussion.

DR. OTIS.—Mr. President, I think that Dr. Morrow has misunderstood me when he says I advised marriage after three years *with or without treatment*. I will say in the first place that my paper read before the State Medical Society was not intended to assume authority on this point. It was an argument only, an argument to show the probable limit of the contagious stage of syphilis, and the reason of my exception to the remark which he has made will be seen by my reading the termination of that paper, as follows: "*With this presentation of some of the facts and arguments which may be brought to bear in favor of the positive termination of the contagious stage of syphilis to three or at most to four years—with or without treatment, I rest my case.*"

That is all, as far as I am aware, that I have said about marriage of syphilitics without treatment. I am certain that I am in favor of syphilitic persons having treatment extending over a period of three full years. Not, however, so much for the cure of the contagious stage of the disease, as for security against the sequelæ of syphilis, which constitute the gravest dangers of the disease. Further than this, I fully coincide with M. Fournier that the treatment should be repeated from time to time according to the particular circumstances of each case during the lifetime of the patient, if he would secure the most complete assurance of immunity from the occurrence of the late manifestations of syphilis.

IN THE DISCUSSION OF THE PAPER OF DR. STURGIS,¹ "IS THERE A CHANCROIDAL VIRUS," DR. TAYLOR said:

I am glad to hear this paper by Dr. Sturgis. Ricord, in his second edition ("*Leçons sur le Chancre*"), in which he recants his former views and accepts those of Bassereau, begins thus: "*Messieurs, un poëte a écrit: L'homme absurde est celui qui ne change jamais.*" 'A foolish man is he who never changes.' I am glad to see Dr. Sturgis follow that noble precept, for to-night his teaching is diametrically opposite to that in his paper in the second volume of the "*International Encyclopædia of Surgery*," New York, 1882. I am glad to learn that he has come to accept the views which Dr. Bumstead and I were the first to

¹ JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, March, 1887.

clearly and sharply enunciate in 1876 in Philadelphia at the meeting of the International Medical Congress. Dr. Bumstead then read a paper on "the Virus of Venereal Sores, its Unity or Duality," which contains nearly and essentially all that Dr. Sturgis has to-night offered in proof, in which he took the ground that there was no essential or specific chancreoid virus, and that chancreoid sores, while they might be the product of antecedent chancreoids, were also due to inoculation with the products of inflammation, simple or syphilitic, precisely as Dr. Sturgis describes in his paper. I shall never forget the scene which ensued, in which Dr. Bumstead encountered the antagonism of every member present but myself. They seemed personally aggrieved that any one should have the hardihood to express any doubts upon, much less endeavor to demolish, the doctrine of dualism. In their minds it was sacrilege. It so happened that my own studies, observations and experiments made over a period of years, and altogether independently of Dr. Bumstead, had led me to conclusions identical with his. I shall always remember the pleasure expressed by my old master that I, his former clinical assistant, had thus arrived at conclusions similar to his. We both felt that a dictum like the following should be forcibly denied. I quote from the work of Van Buren and Keyes: "Chancroid is an affection perpetuated only by contagion, sexual intercourse is not essential. Wherever upon the human body a chancroid is found, there has been deposited pus from another chancroid, under conditions favorable for its absorption. No amount of sexual excess, no degree of uncleanness, no irritation traumatic or chemical, however prolonged, no simple or poisonous ulceration from other specific sources (syphilis, cancer, glanders, etc.), nothing in short can produce chancreoids except chancroid (chancreoid bubo included). So that, as Fournier puts it, if all the patients in the world with chancroid would avoid contact with others until their malady got well, the disease would cease from off the face of the earth." The utter fallacy of these views was clearly shown in Dr. Bumstead's paper and in the discussion, and I think I can, without being considered guilty of immodesty, claim, that the combined labors of that eminent syphilographer and my own, contained in our treatise on venereal diseases, prove the validity of the conclusions above enunciated. I am glad to see that Dr. Sturgis has taken the cases which we used and added a few, which were unessential in the premises, and even thus late has come to coincide with us, in this vital question in syphilography. I am to-day prepared to elaborate more fully than I do in my book upon the nature of venereal sores. So-called chancreoids are often only irritated herpes in debilitated persons, old syphilitics, and persons of plethoric habit and given to drink. Again others originate in purulent vaginal discharges. I am of the opinion that what we call virulent chancroid generally originates in pus from syphilitic subjects. I have facts and observations embracing this whole subject, but I fear to further trespass upon the time of the Society.

DR. F. N. OTIS.—Mr. President, after Dr. Bumstead read his paper in Philadelphia, I made some statements, giving my reasons for thinking chancroid is not specific, and they were much in line with what has been said here this evening. I am entirely with the author of the paper in his belief of the non-specific origin of chancroid, and especially

for the reason that it is known and accepted that chancreoids vary in activity, from those which are highly contagious and rapidly destructive, to those which are feebly destructive and are inoculated with difficulty. This is a well-known clinical fact, and has been repeatedly proven in the experiments with artificial inoculations by Böck and others. "A certain pus is employed ('chancreoids') and re-inoculated until it will no longer produce a pustule: *then fresher pus from some younger chancreoid*, until it also fails."

If this decadence takes place in the artificial inoculation, it is not reasonable to suppose that the same result would be reached by repeated inoculations through venereal contact. Hence the chancreoid, by the continued re-inoculations of venereal contact, would grow less and less virulent, as communicated from person to person, until it finally died out.

Unless, therefore, new foci of contagion were created, *or new virulence added*, chancreoid would long ago have *ceased from off the earth*. We must then take one of these two positions in regard to it: either some added virulence must be accepted as arising from circumstances connected with the venereal contact (since it has been conclusively shown that by simple re-inoculation chancreoid speedily loses its contagious and destructive properties), or that from circumstances connected with venereal contact new chancreoids are originated. It is not necessary that we should be able to explain the exact combinations which increase the virulence of a declining chancreoid, or which give rise to it *de novo*, in order to prove that certain possible conditions really do intensify and even originate chancreoidal action or virus. If there is a difference between the behavior of the chancreoidal virus, when inoculated by means of a lancet, and when inoculated through venereal contact, that difference can only be referred to the circumstances attendant upon the venereal act. How then do the circumstances differ in an artificial and in a venereal inoculation? In the first we have the virus inserted free from local or general circulatory excitement. In the second both are distinctly present. Under circumstances of equal cleanliness and equally free from undue tendency to purulence, the result might not be markedly different. But to the latter mode of inoculation, viz., that by venereal contact, we may have, in addition, various potent influences, as such increased irritation from irritant leucorrhœal, menstrual, and preputial secretions, filth, excessive venereal indulgence. Each one of these added conditions is well known to be capable of initiating local inflammation, and of increasing inflammatory processes already instituted. It can even be shown that a combination of these conditions may originate a lesion which distinctly exhibits loss of tissue, and the secretion of which is capable of setting up a similar lesion on an opposing surface, therefore possessing the contagious property. If this can be proven, it seems to be clear that the difference between a lesion thus produced and the typical so-called *specific* chancreoid is simply one of degree, and it may be logically claimed that circumstances which have been shown capable of setting up such a lesion and which are shown to add to the virulence of a declining typical chancreoid, may, under favoring conditions, produce an actively destructive, promptly contagious lesion, that is to say, a typical chancreoid.

DR. BRONSON.—I desire to enter a word of protest against the sweeping

assertion that the so-called chancroid is only a product of inflammation. I deny that inoculability in generations is the sole test of the chancre, or that the various suppurating lesions which have been produced by the inoculation of simple pus, such as that in an acne pustule, are pathologically identical with the contagious venereal sore. We must take into consideration the entire clinical history of the disease and all of its morbid features which distinguish it most distinctly from the various inoculable sores produced by simple pus. Were the origin of chancroid such as is claimed for it, the disease would naturally be vastly more common. Why then should it be confined almost exclusively to the genitals? Why should not chancroids of the lips arise more commonly? Or if the greater frequency on the genitals is solely due to the greater aptitude of these parts to ulceration, why should not the virulent discharge of a gonorrhœa produce chancre? In the balanitis often attending it, abrasions of the surface occur, and if it is merely the acrid or virulent quality of the pus that makes a chancre, why should not the virulent and acrid discharge of gonorrhœa produce a chancre where such abrasions of the surface are present? The chancroid has an independent clinical and etiological character and a peculiar virulence that imply a special kind of virus.

DR. STURGIS.—Mr. President, I carried this paper further than the one in the Encyclopædia to show that sores simulating chancroids are produced by simple pus, not only upon syphilitic patients, but also upon non-syphilitic persons, and to trace the possible connection which exists between the ulcer of inoculation produced by the pus of irritated syphilitic lesions of certain types and the chancroids. This question of the virulence or the non-virulence of the chancroid had often been discussed by Dr. Bumstead and myself and was by no means new to me. What I contend for in this paper is, that if simple (non-venereal) pus can be inoculated upon non-syphilitic persons, the doctrine of the "specific virus of the chancroid" is very much weakened, if not entirely overthrown. The reason why I did not refer to the class of cases mentioned by Dr. Taylor is because I wished to confine my evidence to cases of a positive nature, into which the doubts inherent to clinical observations should not enter; I therefore quoted the results of direct experiments only.

As to Dr. Bronson's remarks concerning the necessity for virulence, I think it will be found that the ulcers produced by these experiments pursued the same course as chancroids. I do not mean to say that chancroidal pus is not more easily inoculated than other kinds, but I believe that, under certain conditions, simple pus is also inoculable, and if this be so, what becomes of the virulence of the chancroid?

DR. TAYLOR.—Notwithstanding Dr. Sturgis' denial, I must insist that in the article I referred to he took totally different ground from that which he takes to-night. Here are his own words, summarizing his conclusions, which will fully settle the question: "So far, then, no cases have been published or are known which prove the direct descent of the chancroid from syphilis, as those which I have presented (the only cases I can find on this branch of the subject) are all open to serious questions."

"Of course, it would be idle to speculate upon the possibility of future experiments proving this derivation, so that we must at present content ourselves with saying that *the simple venereal ulcer (chancroid) is de-*

rived from the secretion of another chancre, or of a virulent (chancreoid) bubo, and from nothing else. (Italics are used in the original). Nor does the possibility of simple pus being auto-inoculable deprive the fact of any of its importance." (See article The Simple Venereal Ulcer or Chancreoid. The International Encyclopædia of Surgery, vol. 2, page 433. New York, 1882.)

Dr. STURGIS.—The quotation made by Dr. Taylor is too limited, the article should be read at length in order to understand the real views of the writer.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

170TH REGULAR MEETING.

Dr. ROBT. W. TAYLOR, *President, in the Chair.*

Dr. PIFFARD presented a case of

EXTENSIVE NÆVUS VASCULARIS,

covering the entire left side of the face, forehead, and portion of the scalp, in a child two years of age. The growth had been first noticed at the upper part of the nose shortly after birth. Electrolysis had been employed, after which the nævus had extended down over the nose and upper lip, and laterally over the cheek and forehead. The inferior portion of the septum nasi had been destroyed by the growth, and in the regions of the upper lip and a portion of the cheek the enlarged vessels extended through to the mucous membrane, making a thick mass of vessels in these situations. Ulceration had taken place upon the scalp spontaneously. The growth caused great deformity, and suggestions as to the best mode of treating such an extensive nævus were desired.

Dr. FOX advised the employment of the ethylate of sodium as a means of improving the appearance of the face for the time being, but a cure, where the vessels are so deeply situated in the parts, is almost hopeless.

Dr. SHERWELL said he had had some experience in treating these deep circoides nævi, and it had occurred to him also that the ethylate of sodium would do good, and might cause coagulation of the blood in the cavernous portions of the nævus as well. He asked if the child had already had the diseases of childhood. He thought perhaps the conditions present after measles, for instance, might have a beneficial influence on the growth. The lowered state of the system at this time, the fibrinous condition of the blood, etc., might cause the venous sinuses to become engorged and lead to such an ulcerative action as nature has already produced upon the scalp in this case. He would advise exposing the child to measles. He recalled a case of nævus, which he had shown before the Society, occurring in a child of five months, into which he had injected twenty-three minims of pure carbolic acid at different points with great benefit and no bad effects. The Society at that time had not sustained him in the procedure, but the results proved it justifiable. The clot formed by carbolic acid is of a leathery nature, the acid combining with the albumin to form a tough clot, while the injection of iron preparations produces a brittle, crumbling clot and, as Dr. Piffard has said, embolism has followed iron clots. He thinks the acid should be used as concentrated as possible.

DR. TAYLOR asked what was the destructive process, and what the effect produced.

DR. SHERWELL said the enlarged vessels were shrivelled up and abscesses were produced; there was a general clogging up, accompanied by much swelling, which occluded one eye for a time. The patient now looks quite well.

DR. FOX said a knowledge of this case had led him to treat a case in the same manner. He had injected five minims of the acid into a nævus of the lip, and produced a bad slough. He would hesitate to inject a large amount at once in any case.

DR. JACKSON said that some German author had recently proposed a method of treatment which consisted in applying tightly to the nævus a perforated metal plate which had been carefully moulded to fit the parts. The circulation is restricted by the pressure of the plate, and the actual cautery is applied through the perforations. He thought it might work well.

DR. BRONSON asked if any one had used Marshall's method, which consists in penetrating the nævus at various points with blunted needles, having for its object the production of adhesive inflammation.

DR. BULKLEY said he would destroy a small portion of the nævus at a time with the mono-chloro-acetic acid or the crystalline ethylate of sodium, boring into the growth with a sharp stick or match charged with the remedy. He might use electrolysis afterward, but would be afraid to inject carbolic acid.

DR. ALLEN said he should favor the application of the ethylate of sodium to the extended surface, as had been suggested, but he did not agree with the view that the deep situation of the vessels in parts made the case hopeless. He had operated by electrolysis on a nævus in which the tumor extended through the whole thickness of the upper lip, showing prominently upon the mucous surface, with the result of completely destroying the deeper vessels as well as the superficial ones.

In closing the discussion, DR. PIFFARD said the outcome of such a case was very uncertain. As an injection he should give the preference to the perchloride of iron rather than to carbolic acid, which latter drug he recognized, however, as an excellent one for the injection of hæmorrhoids. He would also prefer the use of nitric acid to that of ethylate of sodium, not being satisfied with his results from the employment of the latter. He had used electrolysis in many cases, but the results here, too, were unsatisfactory. Of all methods of treatment, probably none surpasses the actual cautery. As a simple means of applying it, he advises the use of a shoemaker's awl heated to a dull red in a spirit lamp, and forced into the dilated vessels. As it is important to maintain the heat after the puncture, a better result is obtained from the Paquelin cautery introduced just as the iron begins to grow hot. No eschar is produced about the puncture, but the diffusion of the heat produces coagulation and inflammation, followed by consolidation. At a white heat no eschar is produced, but a gush of blood follows the puncture. He would then give the preference to nitric acid as an application to the superficial portions of the nævus, and for the deeper parts would use the Paquelin at a dull heat.

DR. PIFFARD then presented a case as one of

PRURIGO OF HEBRA.

The patient was a woman 50 years of age, whose legs, arms, and portions of the trunk were covered with large papules and tubercles, which had existed for twenty years, and had caused constant and severe itching. The skin over the shins and the forearms was thickened and pigmented from the constant irritation and scratching. The tubercles on the legs were very large and prominent.

In the discussion, DR. BULKLEY called attention to a patient, aged 45 years, whom he had shown to the Society some eight or ten years ago, who had presented much the same lesions as were seen in Dr. Piffard's case. He stated that the disease had been made out to be a chronic papular eczema, with papules and tubercles having an unusual condition of hardness. The patient made a full recovery.

DR. BRONSON said that his views on the disease had changed since he had read

those of Auspitz. This author believed that the disease is a sensory and motor neurosis without any essential lesion. This opinion had appeared to him the most rational, and when a neurosis affecting the extensor surfaces of the limbs, leaving the flexor surfaces exempt, was met with, it was fair to regard such a neurosis thus confined to single portions of the body as a prurigo. Lichen planus of a chronic hypertrophic form, which this at first sight had seemed to resemble, would not be found on these exclusive regions. He would regard the case as a neurosis closely related to prurigo.

Dr. Fox said he had at first regarded the disease as an unusual case of lichen planus, but the more he had examined it the more it appeared like prurigo. Prurigo is not such an uncommon disease in this country in its mild form. In Vienna, he thought the greater number of cases shown were of the form known as "ferox," while cases of prurigo mitis were not presented. He did not regard Hebra as infallible, and believed that true prurigo may get well, and that milder cases of the disease are more common here than is generally thought to be the case.

Dr. ALLEN did not think the case one of prurigo, for the reason that by the patient's statement the disease had begun twenty years ago, at the age of 30, while true prurigo begins in childhood, and that the glandular enlargements in the groin were not nearly so marked as they usually are in prurigo, and the lesions on the legs were much larger than in any cases he had seen.

Dr. TAYLOR said he had been struck with Auspitz's conclusions regarding the disease, and he believed, with him, that this as well as other diseases were apt to deviate from the type form. The diagnosis should not be based on invariable lines. He thought Hebra had described typical cases of prurigo, and cases conforming strictly to the type were not usually seen.

Dr. PIFFARD, in closing, said we had no more right to expect all cases of prurigo to resemble each other exactly than to find every case of eczema or other disease precisely similar to every other case. We must look at the essentials of the disease and not at the epiphenomena, as Dr. Taylor has called them, and he was very glad to hear his views regarding the deviation from the type form in disease. In the case presented he had made out, on careful examination, the essential papules of the disease under the skin, or, more strictly speaking, in the skin itself. At the first glance little is to be seen upon certain portions of the body, but the hand being passed over the surface, more is discovered by the touch than was apparent to the eye. There is but slight change from the normal color. If you irritate any portion of the skin of the body you produce an inflammatory deposit. The first lesion which appeared consisted of small endermic collections which were itchy, persistent, and by long years of scratching have led to plastic infiltration. When compared with the descriptions of prurigo, as given by Hebra, the appearances presented by this case are found to fit them very closely. This is not the form of prurigo described as "ferox." In rational symptomatology, there has existed a terrific irritation, and the lesions which are so large are due to this irritation.

The only similar case which he remembered occurred in a young man whom he had seen some ten years ago. The diagnosis of prurigo was made for the want of a better one.

He regarded the glandular enlargements as secondary manifestations due to irritation of the lesions upon the lower extremities. Other diseases produce the same results, where it is plainly seen that they are secondary, and the irritating cause being removed, they soon disappear. He could not regard these glandular swellings as specific to any particular disease.

As regards lichen planus, he would only say that it was a disease which gets well and never, in his experience, persists as in this case.

A candidate's thesis entitled

A CONTRIBUTION TO THE HISTOLOGY AND PATHOLOGY OF HERPETIFORM HYDROA, was then read by Dr. Bulkley as the paper of the evening.

Dr. BRONSON said he would demur from some of the conclusions of the paper relating to the connection of hydroa with the sweat glands. The distinction between this disease and zoster is no greater than could be accounted for by

differences in degree of inflammation. He was surprised that the writer had not treated of morbus Dühringii or dermatitis herpetiformis, which would seem to be closely associated with this form of hydroa.

DR. FOX said he was pleased with the good work which the paper indicated the writer had done, but he could not agree with him in thinking pathology of so much importance in dermatology. Diagnosis must of necessity rest on a clinical basis, and treatment has to be based on clinical work. All such work is of great value to science, but is not of great practical value.

DR. PIFFARD said he had been the first to call attention to hydroa in this country, and in 1869 had shown a case, together with a wax model, which had fitted exactly into the description given by Dr. Hutchinson at about the same time in the *British Medical Journal*.

So far as regards the anatomy of the disease, many affections have essentially the same histological changes, so far as we can tell with the microscope, and he agreed with Dr. Fox in thinking that diagnosis must rest on the clinical history.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Scleroderma.

I WILL call the attention of your readers, in beginning my letter, to an excellent monograph of 250 pages on scleroderma which has just appeared from the pen of Dr. Bottier. It is a complete *exposé* of the present state of knowledge regarding the disease. Unfortunately, nothing very new of a practical nature is to be found in the book. The modes of treatment which hitherto have seemed to produce the most favorable results are the internal administration of the iodide of potassium or of the salicylate of soda, according to the nature of the case, while externally frictions with cod-liver oil, steam or vapor baths, and more especially the application of continued currents of electricity, have been seen to produce, in a number of cases, an amelioration which has been highly satisfactory.

Treatment of Eczema.

In the clinics of the St. Louis Hospital, Dr. Besnier dwelt upon the diagnosis, the nature, and the treatment of eczema circinatum of the sternal region.

This affection is for the most part marked by small, round, red patches. They are sometimes irregular from confluence, and present at their periphery a sort of border quite distinct, resembling a slight incision; this aspect is entirely characteristic, and takes away all doubt about the diagnosis. This eruption has all the external attributes of a parasitic disease, and numerous micrographic examinations have been made to discover its nature, especially of late. Only spores of various kinds have been found, but no parasites well characterized by special spores and mycelium. Until more definite information is obtained, we must regard it as a variety of eczema. Bazin called it acneiform eczema of the sternum, because certain of its eruptive elements resembled, in a measure, those of acne and are besides perifollicular. It is certain that subjects of an arthritic type are more inclined than others to this dermatosis. Without doubt, this is because of the

abundance of their sudoriferous and sebaceous secretions. These secretions decompose upon the surface of the integument and thus become causes of irritation. To overcome this affection, it is necessary, according to Besnier: 1. To regulate the general condition of the patient, looking after the various functions of the body, and prescribing an appropriate alimentary hygiene. 2. To enforce cutaneous hygiene, removing from the skin the irritating products which sojourn upon its surface. 3. To suppress all other causes of irritation of the skin and particularly the direct contact of woollen and flannel clothing. The patient must bathe the affected portion of the skin each morning with warm water and soap without soaking the parts too much; then having powdered over with starch powder, a piece of old soft linen is placed between the skin and the undershirt. In most cases, these simple measures suffice to cause a disappearance of the eruption. If, however, it persists, we could prescribe an ointment. Dr. Besnier recommends especially in this case one of sulphur, for sulphur prevents the alteration of the products of the glands of the skin. Apropos of eczema of the hairy regions, especially of the hairy scalp, the same author remarks that the differential diagnostic sign between moist eczema of the scalp and seborrhœa sicca is the falling of hair in seborrhœa and its almost complete preservation in eczema, which is an affection penetrating less deeply. In women attacked with eczema of the scalp, an attempt must always be made to preserve the hair; this is often difficult to accomplish, for the affection is particularly rebellious in regions where it penetrates into the hair-follicles. For this form treatment is begun by prescribing local sprays of tepid alkaline vapor, lasting for ten or twelve minutes. The hair is then to be done up upon the top of the head and a rubber cap applied to cover the whole scalp. This cap should be changed morning and evening and washed in cold water without soap. Each morning the spray is used upon the scalp to cleanse it well, and this is kept up so long as there is need of an emollient medication for cleansing the scalp and calming the irritation; then ointments are to be employed. At times, however, we will not succeed with these procedures and will be obliged to scarify the scalp. It is well understood, besides, that we are never to be content in these cases with local treatment alone; a careful examination of the patient must be made in order to determine, from the state of his organs or his constitution, the various indications that the physician should meet, in order not only to cause a disappearance of the lesions for the time being, but to effect a permanent cure.

Pityriasis Rosea of Gibert.

During the past few years, we have seen in France an increase in the number of cases of this interesting affection, formerly so rare, and one which almost invariably causes an error of diagnosis when observed by physicians not well versed in dermatology. During the past year, I have had to rectify several mistakes of diagnosis in this direction.

The three affections with which it is oftenest confounded are eczema, psoriasis, and syphilis. Every one knows that we call in France by the name pityriasis rosea of Gibert (the name of the author who has given the first good description of it) a particular erythemato-squamous affection, characterized objectively by the appearance of small rosy plaques which spread out little by little, varying in size from that of a split pea to double this size and over, reaching at times the size of a franc (twenty-five cent piece). They gradually become scaly, and grow

pale in the centre as they increase at the periphery. At times they form distinct circles, but more often they are somewhat irregular in shape. They first appear usually in the supra- or infra-clavicular regions, spreading later to the trunk and arms, rarely reaching below the knees. Nevertheless, I have seen the disease begin upon the arms, and be limited almost exclusively to these regions. Furthermore, several varieties might be described from the aspect of the lesions. At times the plaques are small, slightly squamous, and scarcely visible; at times they are of a lively red, and so closely simulate an eczema as to deceive; at times very discrete and at others very numerous, even becoming confluent at certain points, especially upon the lateral portions of the trunk. This affection develops with great rapidity, absolutely like an exanthema; it has a cyclic duration, which may vary from four weeks to several months. Its special mode of début, its extensions in the manner described, the slight amount of painful reaction, the superficial nature of the eruptive lesions, their dryness and their spontaneous evolution toward a cure after a certain time, and finally their localization, so characteristic, and the general appearances of the eruption almost always permit an experienced eye to recognize at once this affection, and to distinguish it from the three dermatoses above enumerated.

Since pityriasis rosea has a cyclic evolution, and always terminates in spontaneous recovery, we may content ourselves by reassuring the patient, and prescribing for him certain rules of hygiene to follow. It is always preferable to employ certain means which, perhaps, may shorten somewhat the duration of the disease, and, at any rate, have a beneficial moral effect. Many dermatologists order these patients to take a sulphur bath every second day, and to rub well the red spots with the water of the bath. At times, the skin will not support these baths, which are somewhat exciting, but this only rarely happens. The following is the practice of Dr. Besnier: He orders every second day a tepid bath with bran or starch, into which is placed, according to the irritability of the skin of the patient, from two to four ounces of borax. Further, he orders each night to be rubbed into the diseased spots a small quantity of an ointment made with glycerole of starch, 100 grams, and borate of soda, 4 grams. If the skin becomes too moist, he advises drying the spots with absorbent cotton^o or fine linen, and, if necessary, to powder over with starch powder.

The Treatment of Syphilis by Subcutaneous Injections of Calomel.

Dr. Balzer has been experimenting in his service at the Lourcine Hospital, in Paris, with the method of treating syphilis which has been praised by Scarenzio and Smirnoff, and which consists, as all know, in giving a small number of injections deep into the substance of the muscles. In order to avoid the production of abscesses which form quite frequently when the formula of these authors is employed (calomel, water and glycerin), the French author employs as vehicle the oil of vaseline. The following is the formula which he gives: Calomel, fifty centigrams; oil of vaseline, ten grams. The few results which he has already obtained lead him to believe that this medication is quite active. As soon as Besnier learned of the preceding researches, he began testing the method at the St. Louis Hospital, and has ably expounded his views upon the question in one of his recent clinics. According to this author, it is necessary to attempt to modify the treatment of syphilis as employed at the present day. It is, in fact, too long, often difficult to carry out. The patients become dyspeptic, have

stomatitis, and become discouraged. Infants cannot withstand the internal administration of mercury; they are attacked during its administration with enteritis, and die of athrepsy. Subcutaneous injections of the bichloride of mercury have been tried on a very large scale in Paris, especially in the Lourcine and St. Louis Hospitals, and nearly all the physicians have given up the method. The patients are not willing to submit to it, the insertions of the needle were too numerous and too painful, and their syphilis was scarcely more modified than by the ordinary methods. Besides it was a hospital treatment which in France could never be extended to private practice, on account of the great number of medical visits required and the pain caused by the injections. This procedure should then be exclusively reserved for certain particular cases which fail to give way to the other methods, as for example in certain severe cases of visceral syphilis. Entirely different is the method of Scarenzio, since it consists of introducing into the tissues preparations of insoluble mercury which form there natural reservoirs, so to speak, in which the mercury alters little by little and slowly gains access to the circulation according to the needs of the case. From forty to fifty centigrams of calomel suffice, according to this author, for a treatment of a case of syphilis. It is slowly transformed into bichloride of mercury by contact with the fluids of the organism. Scarenzio introduced this quantity at four sittings, about ten centigrams at each injection. His first experiences date from 1864, but the method did not become generalized because of the many inconveniences which it represents. It produces severe pain, causes deep-seated abscesses, and at times phlegmons of a severe nature. Nevertheless, it has been taken up again of late years in other countries. Dr. Besnier believes that we must use it experimentally in modifying it; for, if we could free it from its inconveniences, it would constitute a real progress, admitting that it has all the efficacy attributed to it. Here is the detailed procedure of the physician of the St. Louis Hospital. He deems it indispensable to take all antiseptic precautions. The calomel is incorporated with the petro-vaseline and well shaken, to put the insoluble substance in as perfect suspension as possible, and the mixture is then boiled a few seconds before making the injection in order to sterilize it. The operator should wash the hands in a mixture of alcohol and liquor of Van Swieten, and cleanse the part where the injection is to be made with some absorbent cotton wet with the same solution. The needle of the syringe should be cleansed with the same solution, and before inserting be dipped into boiling oil or glycerin. The choice of location for making the injection is a point of the buttocks about three centimetres below the crest of the ilium and an equal distance above and to the inner side of the great trochanter. The mass of muscles in this region are favorable for the injection, and they do not support the weight of the body in sitting. The skin is displaced somewhat, so that there is no direct continuation of the puncture of the integument and that of the deeper tissues. The insertion of the needle (which should be oiled, as before said, and two or three centimetres, long) is done quickly at one stroke down to the guard. By operating this way, the patient scarcely feels the introduction of the needle. The injection is then made gently, but a certain force must be employed to secure a passage of the emulsion into the tissues.

With the petro-vaseline as excipient, this latter part of the operation is not painful. The region operated upon is now covered with a compress or a leaf of cotton wet with an antiseptic liquid. Dr. Besnier does not require his patients to remain in bed for three days, as other authors have recommended. If this

measure of precaution is necessary, he says, with reason, that it is of itself the condemnation of the method. He permits his patients to get up and go about. In from twenty-four to forty-eight hours after the operation, a slight inflammatory reaction takes place and a slight oedematous swelling about the mass of injected calomel. Eight days after the injection, at the point where it was made, a node, painful upon pressure, and of the size of a small nut, can be made out deep in the tissues.

In many cases, no further local disturbances have been noted, and the syphilitic manifestations have appeared to grow rapidly better, without mercurial stomatitis being produced. Already, however, with the new vehicle and all the antiseptic precautions, Dr. Besnier has had deep painful abscesses form in two female patients. More numerous experiments will show whether these accidents can be entirely avoided, and if the method prevents the subsequent manifestations of syphilis from appearing, what quantity must be injected to neutralize the syphilitic principle.

Treatment of Stricture of the Urethra by Gelosin Bougies.

Dr. Bedouin has recently recommended the use of gelosin to produce a gradual dilatation of stricture of the urethra. As is well known, this substance is obtained from the gelatinization of water in which has been dissolved, by the aid of heat, a small quantity of alga or sea-weed of Japan. Left to itself in a medium devoid of humidity, gelosin slowly loses its water and becomes a sort of residue of a dry, woody appearance, and of much less volume than in its original condition.

If, then, it is brought into contact with liquid substances or humidity, it tends to resume its primitive volume by reabsorbing the water it has lost. The author, basing his work upon these facts, constructed a series of cylindrical bougies of different calibre from this dried substance. They are introduced within the canal, where they dilate gradually from the urethral secretions, and dilate at the same time the constricted portions. Their cohesion and solidity are sufficient, it appears, to prevent fear of their breaking. Various medicinal substances may be incorporated with the gelosin to act as topical application to the urethral mucous membrane, such as cocaine, iodoform, corrosive sublimate, boracic acid, etc. I should add that this new method of treatment is only in the period of investigation, and that the results obtained are not as yet numerous enough to carry conviction with them.

L. BROCCQ.

PARIS.

BACTERIAN ERUPTION FROM A WOUND.—At the French Congress of Surgery, M. Nepveu read notes of a case of a woman of thirty-six, who had sustained an injury from falling on her hands. The third phalanx of the thumb was severely dislocated and a large superficial wound occurred. Local antiseptic treatment with sublimate and iodoform was adopted. A vesicular eruption appeared, which spread from the hand to the whole body; this was checked by an iodoform dressing. Lymphangitis was absent. On examination, a quantity of bacteria were found in the contents of the vesicles. The progress of the symptoms were as follows after the wound: suppurative arthritis, bacterial eruption proceeding from the arthritis.—*Medical Bulletin*, Jan., 1887.

Selections.

SYPHILITIC REINFECTION.

DR. RABITSCH-BEY, of Cairo, gives, in the *Wiener Med. Wochen.*, No. 42, 1886, four cases which he considers instances of reinfection of syphilis. He says that, with other analogous clinical experiences, the proposition that man can acquire syphilis more than once does not disagree. If, then, lues is a chronic infectious disease, it must, according to experience, often, after a longer or a shorter time, become eliminated from the system.

Just as with other virus diseases: malaria, typhus, variola, which, being cured, the individual becomes capable, nevertheless, of reinfection at an earlier or later period; so it is with syphilis. The facts warrant acceptance of this view.

The question is asked: When is the system of a syphilitic susceptible of re-infection?

(1.) If the former syphilis is entirely eliminated from the system? Or can (2.) a second fresh syphilis be inoculated upon a first; or (3.) Is the system at any given time during the late evolution of the disease ripe for re-infection?

The first question is answered by what precedes. In regard to the second, the researches of Ricord give us a positive answer. In his work of 1836, he says: "Le chancre en réparation, inoculé sur le porteur, donne toujours un résultat négatif." As none of his auto-inoculations from true chancres succeeded, we must conclude from these experiments, that the syphilitic virus is not inoculable in one who bears the initial lesion of syphilis. I must here oppose the objection that now and then two or more initial lesions are found coincidentally upon the same individual, of which, at the proper time, I will give instances. This condition is, however, the result of a single infection, and to be considered as due to the absorption of the virus at several points at the same time, just as in vaccination six pustules can develop at once, but if a single inoculation of the virus has been successfully made, after a few days no further inoculation will succeed.

The vaccination pustule and the induration of chancre are the expressions of the saturation of the system with pock or syphilis virus. This proposition is sufficiently proven and universally known to need no further comment.

It remains still to examine into the question of whether in any of the later periods of the evolution of syphilis the patient becomes capable of being again infected.

Ricord refers to the case of an old soldier who had suffered from an inveterate attack of syphilis which had defied all treatment. The soldier became infected with a fresh syphilis, and was then cured of both old and new syphilis by another course of treatment. We are not informed what period of evolution the original syphilis had reached when the new was contracted.

The author himself gives a case from his history book, in which in January, 1885, a patient had a chancre on the left side of the frenulum followed by secondary manifestations, and in March, 1886, a new chancre on the right side, followed by roseola. The man died six months later of pneumonia. He does not comment upon the case, leaving it to each reader to draw his own conclusions. He urges further investigations and record of observations that this important question of re-infection may be finally settled.

ACUTE BLENNORRHAGIA TREATED BY INJECTIONS OF BICARBONATE OF SODA.

DR. CASTELLAN has recently experimented at the Saint Mandrier Hospital, and found that in twelve cases of gonorrhoea the pus was always acid. Considering it an established fact at the present day that the disease is of a parasitic nature, and his observations leading him to believe that the parasite can exist in an acid, but soon becomes sterile in an alkaline medium, he regarded it as logical that, in rendering the pus alkaline by appropriate treatment, the parasite, which makes the affection transmissible, would disappear.

He made use of solutions containing from eight to ten grams of the bicarbonate of soda in a thousand grams of water, which he injected three or four times daily.

Seven or eight days of treatment sufficed to render the pus alkaline, after which the disease gradually improved and disappeared.

His conclusions are as follows:

1. The urethral pus at the onset of the disease is nearly always acid. This acidity is more or less pronounced.
2. The treatment by the bicarbonate of soda rapidly diminishes the quantity of the discharge. It rapidly causes the sharp pains attending urination to disappear or to be greatly lessened.
3. In chronic urethritis, and in cases already treated by opiates and the usual injections, it brings about a rapid cure.

TRANSMISSION OF PSORIASIS TO RABBITS.

At the meeting of the Berlin Medical Society of November 11, 1885 (*Deutsche Med. Zeit.*, No. 93, 1885), Lassar showed some rabbits having an eruption closely resembling psoriasis, which had appeared after he had rubbed separate regions of their bodies with a mixture of epidermis scales, blood, and lymph, and particles from the substance of the eruption itself, of a man suffering from a case of typical psoriasis. Encouraged by this communication to make a repetition of the experiment, Dr. Tommasoli (*Gaz. degli ospitale*, No. 43-44, 1886) found that while his researches did not altogether confirm those of Lassar, and indeed in certain ways differed greatly from them in results, still he believes that repeated experiments are advisable and necessary before we can have a definite result from them.

From his researches, the author reached the following conclusions:

1. With a mixture of blood, lymph, and epidermis scales taken from the eruptive lesions of a psoriatic patient, there can be produced, in rabbits, a skin disease extremely like psoriasis in man.
2. The diseased condition produced in this manner in rabbits is transmissible to other rabbits.
3. The transmission can be effected in various ways, namely, from man to rabbits simply by the application of the above-named mixture to the skin, or by injecting the same into the abdominal cavity, and also from one rabbit to another in the same manner, or by subcutaneous or intra-peritoneal injection of blood taken directly from the jugular vein.
4. The incubation period is shorter if the injection is made from animal to animal than if the transfer is made from man to rabbit.
5. In the former case, the skin eruption is milder and of much shorter duration.

9. Finally the condition of the rabbit (in respect to color, greater softness of skin in albino animals) has little or no influence upon the extent and intensity of the eruption. Microscopic examination of excised portions of the skin of infected rabbits showed changes which essentially correspond with those found in the skin of psoriatics, so that the author believes we must, from a pathologico-anatomical stand-point, admit of a connection between the affections.—*Deutsche Mediz. Zeitung*, No. 76, 1886.

ON REPRODUCTION OF THE SYPHILITIC VIRUS.

PROFESSOR NEUMANN made at the last meeting of the Imperial Royal Society of Physicians of Vienna an interesting communication, which is a very important contribution to the doctrine of syphilis. In a part which he read on the Different Centres of Reproduction of the Syphilitic Virus, he first discussed the opinions of Virchow and Baerensprung as to the anatomical changes which were to be found in parts of the skin and mucous membrane of individuals who had been affected with syphilis. The speaker then communicated the results of his own researches, and said that, after all clinical symptoms of the syphilitic affection had disappeared, he nevertheless met with numerous exudation-cells of a round and spindle-shaped form in the skin and the mucous membrane. These cells, which were very infectious in the recent stage of syphilis, augmented and proliferated very quickly. In the recent stage they could infect healthy individuals if these were deprived of the epidermis. As to the tertiary stage of syphilis, the exudation-cells grew and augmented much more slowly, were less infectious, irritated the neighboring tissue to inflammation in a less degree, and did not spread on other localities when proliferating and augmenting. In a later stage they inclined towards the formation of connective tissue and hypertrophy, and at last underwent a caseous and destructive process. Hence these exudation-cells were always present in the skin and the mucous membrane during the latent state of syphilis, and continually formed a source of danger for the health of the individual. The patients in whom the clinical symptoms of syphilis had already disappeared were, therefore, by no means to be looked upon as cured. Anti-syphilitic treatment should be continued, but as the ordinary remedies, like mercury, iodide and their preparations, when continued for a long time, seriously affect nutrition, the therapeutical task became very difficult. The speaker illustrated his opinion by some cases which had come under his notice. Among other specimens, Professor Neumann examined the tissue of the cutis of that part of the perineum on which swellings and moist papules were so often observed, taken from individuals who had suffered from syphilis a year before. Though this part did not show any abnormal change externally, he found considerable changes in the microscopical examination. The tissue of the cutis was infiltrated with round cells, the vessels dilated, their endothelial cells as well as their nuclei enlarged; in the adventitia and the perivascular tissues there was a great number of granulation cells; moreover, there were numerous transverse sections of lymphatic vessels. Another interesting case reported by Professor Neumann was that of a person who had been affected, two years ago, with a maculous syphilide, psoriasis palmaris, and papules on the lips, and who had been treated at the speaker's *clinique*. Microscopic examination of the mucous membrane of the lower lip of the individual in question, though outwardly normal, showed, in the subpapillary layer, crowded vegetations of round cells and enlarged papillæ.—*British Med. Journal*, Jan. 29, 1887.

SALICYLATE OF SODIUM IN ACUTE ORCHITIS COMPLICATING GONORRHŒA.

DR. M. A. PIGNORET (*Thèse de Paris*) states that Dr. E. Henderson, of London, was the first to write on this subject, in the *Lancet* (1882, page 1,027). This author gave it in twenty-grain doses every hour with great success, and on the pain being relieved, he stopped or reduced the dose. The present writer details a number of personal observations in which he used the remedy in the Paris hospitals, proving that it gives good results. He sums up his conclusions as follows:

1st. In gonorrhœal orchitis, salicylate of sodium will bring about a diminution of pain in a few hours, and in a longer time it will cause its disappearance.

2d. It acts well above all in cases that have acute epididymitis.

3d. When the inflammation of the cord is intense, the remedy will fail.

4th. In the large number of cases treated, the resolution of the swelling commenced very much quicker than in cases submitted to other treatment, and in a week or ten days the cure was complete, leaving nothing but a slight induration.

5th. This medication, then, has the advantage of allowing the patient to get about within a day or two at most. It is simple, harmless, and appears to be superior to all other forms of treatment for this complication.—*Phila. Med. Times*.

Books and Journals Received.

On the Mode of Development and Cause of Molluscum Fibrosum and the Question of its Relation to Acrochordon and other Cutaneous Disorders, by R. W. TAYLOR, M.D. (Reprint).

Demonstration von Leprazellen in Hautschnitten (in Bindegewebsspalten, Blutgefässen, Schweissdrüsen u. s. w.) von HERR TOUTON (Wiesbaden), (Reprint).

Discussion zu Dr. Unna's Vortrag: Zur Histologie und Therapie der Lepra, von HERR TOUTON (Reprint).

Ueber Localisirte Hydrargyrose und ihre Laryngoskopische Diagnose, von DR. SCHUMACHER (Reprint).

The Natural History and the Treatment of Syphilis, by DR. SCHUMACHER (Reprint).

On Chronic Skin Diseases treated by the Waters of Aix la Chapelle, by DR. SCHUMACHER (Reprint).

Beiträge zur Therapie des Eczemas, von DR. GEORGE LETZEL (Reprint).

Bericht über mit Mitteln der Humboldt-Stiftung unternommene Reise nach den Sandwichs-Inseln zur Erforschung der dort herrschenden Lepra, von DR. ED. ARNING (Reprint).

Vesical Irritation in Women, by VIRGIL O. HARDON, M.D. (Reprint).

A New Universal Syringe and Aspirator, by DR. TILDEN H. BROWN (Reprint).

The Metro-Urethrotome, by DR. TILDEN H. BROWN (Reprint).

Rubella (Rötheln), by I. E. ATKINSON, M.D. (Reprint).

Scarlatina and Scarlatinal Eruptions following Injuries and Operations, by I. E. ATKINSON, M.D. (Reprint).

The Care of the Skin, by J. CLARK MCGUIRE, M.D. (Reprint).

CORRECTION.—In Dr. Sturgis' article, page 96, line 18, for "chancroid," read "chondroid."

JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

VOL. V.

MAY, 1887.

No. 5.

Original Communications.

EDITORIAL NOTE.

A WORD of explanation is due the readers of this JOURNAL for the non-appearance of the portrait designed to illustrate Dr. Duhring's notes of a "Case of Unique Linear Distribution of Cutaneous Lesions of Unknown Nature" in the April number.

The facts are that an engraving was made of the colored picture furnished by the author, the proof of which was accepted as satisfactory. The impressions printed for the JOURNAL proved to be indistinct and so unsatisfactory, from an artistic point of view, that they were rejected. The discovery of the failure of the prints was made too late to admit of its correction without delaying the issue of the JOURNAL unseasonably.

A FURTHER CONTRIBUTION TO THE STUDY OF MOLLUSCUM
FIBROSUM; ETIOLOGY; FIBROMATOUS INFILTRATION
AND ITS RELATION TO KELOID.¹

BY

R. W. TAYLOR, M.D.,
Surgeon to Charity Hospital.

THE various forms of connective-tissue new growths of the skin, which include scleroderma, morphea, xanthoma, molluscum fibrosum, and keloid, can to-day be quite clearly differentiated clinically. The pathological anatomy of

¹ Read before the Section on Surgery of the New York Academy of Medicine, February 14, 1887.

these affections, however, is in a far less satisfactory condition, and much has yet to be learned before sharply drawn lines of the histological appearances of these affections can be laid down. This lack of pathological knowledge is felt mostly in the study of scleroderma and morphœa, and results in uncertainty of opinion as to whether they are really two distinct affections, whether they are simply varieties of one affection, or whether they are more or less remotely allied to one another. The truth is, that connective-tissue new growths so often differ from the type-form and so frequently merge the one into the other that it is almost impossible, from a pathological standpoint, to clearly and sharply differentiate them. This is particularly true as to the fibromata, in which group is included molluscum fibrosum and keloid, and which the investigations of Virchow, Billroth, Rindfleisch and von Recklinghausen show to be related to neuro-fibroma, elephantiasis mollis, lymphangio-fibroma and neuropathic papilloma (*nævus unius lateris*, v. Bäremsprung). In my previous paper¹ I attempted a general clinical study of molluscum fibrosum; in this essay I shall present clinical evidence as to its occasional origin, when localized, in traumatism and also shall give prominence to the fact that, in addition to the typical molluscous growths, there is a clearly marked form of fibromatous infiltration of the skin itself, which in its histological elements resembles the more common affection. This fibromatous infiltration is little known in medical literature, has never before been clearly portrayed, and has been regarded as a rare form of keloid.

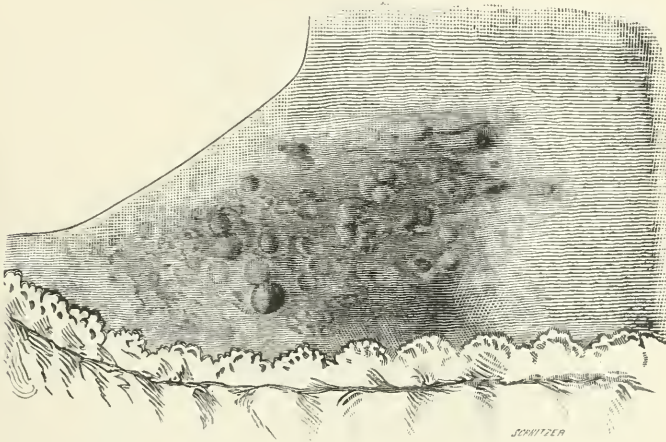
The basis of this essay are the two following cases, together with many collateral facts gleaned from a study of the various forms of connective-tissue new growths of the skin:

Ellen B., aged 47, English, married; was admitted to Charity Hospital September 22, 1886, for leucorrhœa and chest trouble. Examination of the lungs shows dullness on percussion and emphysematous breathing and area of liver dullness less than normal—owing, perhaps, to indulgence in alcoholics. She is, withal, a fairly well-nourished woman. The history of her case is as follows: In 1859, during a brawl, she was bitten by her husband on the left shoulder, at the upper and outer border of the scapula. The wounds thus made were about an inch apart, the one nearly above the other. They bled slightly, but were not the seat of pain, then or at any time since. Very soon, perhaps in

¹ "On the Mode of Development and Course of Molluscum Fibrosum and on the Question of its Relation to *Acrochordon*." This JOURNAL, February, 1887.

a month or two, a round tumor of the size of a pea appeared upon the site of the upper wound. This gradually grew larger and was followed by a similar tumor on the site of the lower puncture. The woman is positive that these tumors corresponded exactly to the points of insertion of the teeth. They grew slowly and gradually, and reached, in about a year, the size of a white grape. Around and beyond these tumors the patient noticed that the skin became hard and firm, the process of extension being, according to her account, very slow. It was never accompanied by pain or any disturbance of sensation. About ten years ago, the patch reached the area it now occupies, and has since remained unchanged.

Her family history, as regards tumors and cancer, is



negative. At the time of the bite, she was in good health, and so remained for years. Subsequently to the date of the bite-wounds, the parts were not injured nor subjected to any undue pressure, or indeed to any disturbing influence. The woman was positive that her husband's bite was the sole cause of the skin-manifestations, and was of the impression that her subsequent tumors were due to the malignancy of the bite of a very angry man, infuriated by drink. The woman was under my care years ago for vulvar chancroids. She had never suffered from syphilis. She made no mention of the present affection, which was discovered by my assistant, Dr. J. A. Bosch, while examining her chest. The following are the appearances as

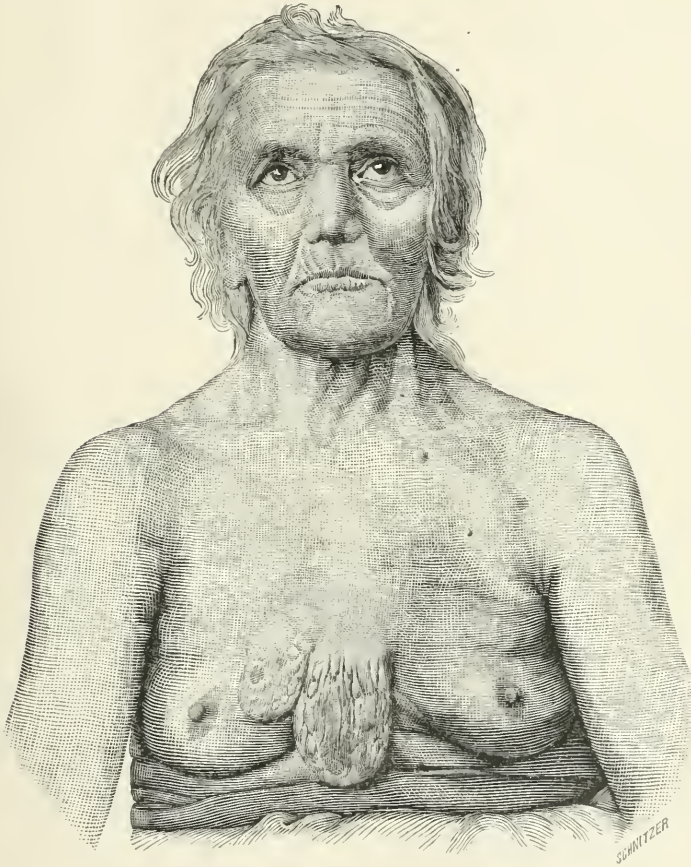
seen to-day, and shown in the woodcut, which is taken from a photograph:

Near the outer end of the spine of the scapula are two pedunculated tumors, possessing the features of molluscum fibrosum in its mature state. Around and beyond, towards the median line, and extending somewhat in the oblique line of the ribs, is a patch of morbid skin about two and one-half inches wide by four inches long. It presents a hard, firm sensation to the touch, as if the skin proper was much thickened and condensed. Pinching of a fold shows that the infiltration does not extend deeply into the subcutaneous connective-tissue layer, since it yields to the grasp and does not present the hide-bound sensation found in scleroderma, but its consistence is quite as firm as that of keloid. Handling of tumors or morbid patch gives no pain. Its surface presents a ridged and rather uneven appearance, as if the infiltration into the skin destroyed its level plane, and threw it into a mass of slight undulations. The color is for the most part normal, but on the more prominent, rounding, wavy elevations the normal hue of the skin of these points is increased to a slight pink. It is evident that this pink color is not abnormal pigmentation, but due to slight and mild stasis of the most superficial vessels, caused by compression of the infiltration. A portion of this morbid skin was excised by me and prepared for the microscope by my friend, Dr. G. L. Peabody, who found the whole derma infiltrated with fibrous tissue of the same character as that found in the older and firmer tumors of molluscum fibrosum. There was an excess of the fibres of connective tissue, which were not soft and cedematous as in young tumors, and there was a proportionately small quantity of cells. The papillæ and the glandular appendages of the skin were normal.

The microscope, therefore, fully confirmed the diagnosis I had made, namely, of tumors of molluscum fibrosum with peripheral infiltration of the adjacent territory of the skin with fibrous tissue.

Barbara M., German, aged 64, was until recently a patient in Charity Hospital. She presents a deformity of the chest-walls which resembles the pigeon-breast of rachitis and also ankylosis of the upper cervical vertebræ, from which sharp bony outgrowths jut backwards and produce pressure and tension upon the integument of the occiput. On the anterior chest-wall, between the breasts and just over the ensiform cartilage, is a pendulous tumor three inches wide at its base and about

four inches long. This outgrowth looks precisely like a hairless scrotum, and presents to the touch the same soft sensation which that appendage does. When pinched, it gives much the sensation of an old and voluminous varicocele, due to the bundles of fibrous tissue contained in the tegumentary enve-



lope. This feature is usually observed in dermatolytic flaps and large pendulous molluscous tumors. To the right of the base of this molluscum pendulum, and involving the upper and inner region of the corresponding breast, is a less extensive and less prominent sessile tumor which presents the same characteristics as the larger one. At the margin of the hair, just over

the region of the atlas and axis, are two well-marked pedunculated molluscous tumors of the size of nutmegs. The woman, who by the way is not very intelligent, says that when six years old she was terribly beaten and trodden upon by her step-father, and as a result she has the above-mentioned deformities and tumors.

The first point of interest presented by both of these cases is the origin of well-marked fibroma molluscum tumors in traumatism. In the first case, the two tumors are small and pedunculated, while in the second, in addition to two such tumors, we find one of the sessile and one of the pendulous variety. These two cases, therefore, present all the typical varieties of tumors of molluscum fibrosum. There is, perhaps, no subject in dermatology in a more unsatisfactory state than that of the etiology of molluscum fibrosum. While most authors are silent, others state the cause as unknown. Others, again, speak vaguely of scrofula and heredity, of a dyscrasia, or of a diathesis as being the underlying cause. Hebra says that, in his experience, subjects to this form of growth are mentally and physically below par, to which Hardy replies that his opinion is not at all in accord with that view. I myself have seen the affection in healthy persons with fair average intelligence. Schwimmer ("Handbuch der Hautkrankheiten," Ziemssen) speaks of local irritation as the cause, and casually alludes to a case in which it followed a wound. The clear history of my cases proves the truth of this remark. I think, therefore, that we are now warranted in making the statement, that *localized molluscum fibrosum may have its origin in traumatic causes*. The evidence presented by my cases warrants the opinion that the wounds causing these tumors must be of such severity as to damage the subcutaneous connective-tissue layers.

A point of great clinical interest is presented by the first case. The teeth-wounds undoubtedly caused localized hyperplasia of the fibrous tissue deep down under the skin. This resulted in the formation of the two molluscous tumors. What is singular is, that the morbid process did not end there, but that from the region of the tumor proper a more superficial fibrous-tissue growth began which was seated in the middle and lower strata of the derma. There were, therefore, two forms of new growth, the one beginning subcutaneously and pushing through and above the skin, the other a well-marked infiltration into a considerable portion of the skin proper. Von Recklinghausen, in

his admirable monograph, brings forth many facts to prove that there is an intimate relation between the nerves of a part and the development of fibromatous tumors.¹ The history of this case seems to point to a nervous origin of the lesions. The question suggests itself, Did the teeth of the husband wound a nerve or nerve-filament and was this localized irritation the beginning of the hyperplasia which went on until more or less of the territory to which the nerve was distributed was invaded? The shape of the patch and the history of the growth would seem to point to this as the only solution of its origin.

The second point of interest in the first case is the fibromatous patch, which in its appearances is wholly unlike the classical connective-tissue new growths of the skin. A skilled observer would certainly never regard it as either scleroderma nor morphœa, much less consider it a form of xanthoma. From its history, course, situation, and appearance, it might be taken for a rare form of keloid. I think that, had I seen the patch without the accompanying well-marked tumors of mollus-

¹ Von Recklinghausen's monograph ("Ueber die Multiplen Fibrome der Haut und ihre Beziehung zu den Multiplen Neuomen," Berlin, 1882) is a notable contribution to the study of connective-tissue new growths of the skin, and is in direct line with Virchow's classical investigations. It is based mainly on a post-mortem case in which the author found the co-existence of fibroma and neuroma. The microscopic study, aided by the appliances of modern technique, is most thorough and exhaustive. Von Recklinghausen speaks with much complacency of his rare good luck in finding such a case, and evidently thinks that he is the first to call attention to the coincidence and relation of these two forms of new growth. In this, however, he is mistaken, since that was first done by my friend, Dr. I. E. Atkinson, of Baltimore, in an article entitled "Observations of two cases of Fibroma Molluscum," in the *New York Medical Journal*, December, 1875. Dr. Atkinson says: "In addition to the tumors of fibroma molluscum, there exists scattered over this man's body a second and distinct set of tumors entirely subcutaneous, generally about the size of a coffee bean, * * * and evidently false neuromata." Atkinson found upon microscopic examination the usual features of the fibroma, and of the histological appearances of the neuroma he says: "The neuroma was made up of a dense fibrous tissue, with a rather free distribution of spindle-cells. Its characteristics were those of ordinary fibroid tumors; no traces of nerve filaments could be made out; in fact, neither from the microscopic nor clinical appearances of the tumor could it be diagnosed as a false neuroma. This diagnosis was reached through the observation of other similar tumors, whose connection with nerves was unmistakable, but of which specimens could not be obtained, as there would have been necessitated an additional operation, to which the patient would not consent." Von Recklinghausen describes the appearances of the neuroma in his case as follows: "The neuromata show everywhere in the clearest possible manner the condition of soft fibroma, not the slightest new formation of nerve-fibres nor any fatty degeneration or disintegration of the same; but nerve-fibres in good condition can be followed easily through the thicker neuromata, only a few fibres being diminished in size, but even they containing myelin. On the other hand, an accumulation of connective tissue running in many bundles of the finest fibrous textures in the long diameter, with small and rather flat, somewhat oblong connective-tissue cells interwoven with a coarse network of blood-vessels." As a clinical groundwork, Von Recklinghausen, besides his own cases, gives quite full abstracts of cases found in the literature of fibroma and of the ordinary neuroma, but, singular to relate, of Atkinson's essay he says that, at the time of writing it was inaccessible to him.

cum fibrosum, I myself should have regarded it as an example of an anomalous form of keloid. I find that that eminent surgeon, Mr. Jonathan Hutchinson, has seen two cases similar to mine of fibromatous patches, but without the co-existence of the molluscum tumors, and has described them as a variety of keloid.

In his very interesting paper¹ "On the Conditions which Precede Keloid, and on Some Rare Forms of that Disease," he reaches the conclusion that with keloid, as with other skin diseases, we must not expect too close a conformity to the type-form. He divides the affection into three forms, the first two being the classical varieties; first, that with much tendency to spread by claw-like processes; second, that in which there is little tendency to invasion of parts beyond the scar upon which it originated, and which sometimes shows a tendency to undergo involution. The third division is of most interest to us in this connection. Mr. Hutchinson thus speaks of it: "The keloid growth is deeper and never produces the glossy, superficial, elevated, spurred patches which occur in the others. These cases are very slow, show but little tendency to spontaneous disappearance. They do not develop in connection with large scars, but rather with inflammatory damage of the skin. They are less prone than the others to recur after excision." He further gives the details of two cases, which I will copy in brief.

A young woman (about 19) had a hard mass in the skin over her left breast, formed of two indurations, almost joining one another. The larger was of about an area of an inch. They were seated in the deeper portions of the skin, and projected a little above the surface and had abrupt margins. These were occasionally the seat of pain and itching. A year after excision, no return had been noted. They were composed of fibrous tissue.

Hutchinson's second case was that of a sea captain, upon the front of whose chest (the proper keloid region) to the left of the median line, was a patch three inches long by one and a half wide. The appearances were very different from those of common keloid, for *the growth was in the skin and did not rise about its surface* (italics are mine). The hardness was great, but ill-defined, and the patch was more lumpy and thicker in some parts than in others. When it involved the cutis, which it did in most parts, its surface was pale almost to

¹ *Medical Times*, May 23, 1885.

whiteness, and although smooth, not glossy. The patch had been present more than twenty years and was increasing. It was excised, and by the microscope was found to be formed of a dense fibroid thickening of the corium. There had never been any itching or pain. Three years after extirpation, there was no indication of recurrence.

A study of these cases, supplemented by the facts of pathological anatomy, shows that, besides keloid, there is a rare form of connective-tissue infiltration of the skin which presents clearly-marked characters. It consists of a more or less diffuse patch of skin thickened in its entirety, and seemingly without involvement of the subcutaneous tissue. To the eye it is of normal hue or perhaps slightly pinkish, not as deep, however, in color or as glossy as keloid. The surface is ridged, undulating, as if the condensation of the skin had thrown it into a mass of slight waves.

At the periphery of the patch, which is of more recent origin, the tendency to slight elevation is greater than in its centre; in no place, however, is the salience peculiar to keloid to be observed. The patches are sharply margined and they grow chiefly in their longitudinal direction from the whole margin, and there is nothing to be observed in their increase akin to the claw-like processes of keloid. In point of slowness of growth these fibromatous patches resemble keloid; but they differ from that affection in never undergoing spontaneous involution, which is somewhat infrequently observed in keloid. While keloid is frequently the seat of pain and hyperæsthesia, these patches seem to be indolent and painless, though Mr. Hutchinson says that the patches upon the girl were occasionally the seat of pain and itching. In my case there was no disturbance of sensation. These fibromatous patches, like keloid, show no tendency to malignancy, nor do they, like morphœa and scleroderma, undergo contraction and throw the skin into ridges and folds. They seem to show a predilection to development in the regions most commonly the seat of keloid, the sternal and the supraclavicular. While in general keloid follows as a result of superficial wounds of the skin, such as scratches, burns and blisters, actual cautery and sunburn, and upon the scars of leech bites, small-pox, acne, herpes zoster (Jackson), syphilitic ulcers, etc., the fibromatous patches result from deep-seated injury to the skin and subcutaneous connective tissue. Finally, unlike keloid, which upon extirpation almost invariably returns in situ, the observations of Mr. Hutchinson show

that in the fibromatous tumors there is no tendency to recurrence after removal. This fact is of great importance in prognosis.

My studies lead me to think that of all skin affections keloid is the one least likely to vary from the type-form. Confusion exists in the minds of many regarding it, for the reason that under the term keloid every form of hypertrophic cicatrix is included. While there may be a histological similarity between the two forms of new growth, clinically they are distinct. In my judgment, the term keloid should be limited, as Alibert intended it should be, to the peculiar pinkish elevated patches of new growth, from the margins of which claw-like processes jut out, presenting the semblance of a crab. In hypertrophic cicatrices, there is little or none of this tendency to claw-like outshoots, nor indeed to peripheral extension, though in color they may resemble more or less closely keloid. The division of this group which I think most rational and borne out by clinical observation is as follows: first, keloid in the limited sense indicated; second, hypertrophic cicatrices, and third, patches of fibromatous infiltration.

40 WEST TWENTY-FIRST STREET, NEW YORK.

SOME OBSERVATIONS UPON THE MODERN TREATMENT OF URETHRITIS.¹

BY

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IN response to an invitation from the President of this Society I will present, this evening, a few facts observed during the past few months, in the treatment of urethritis, at the Out-door Department of Roosevelt Hospital.

These facts are of interest chiefly on account of their being observed during a series of experiments undertaken to test the efficacy of certain methods of treatment, which have recently been suggested, and for which positive claims of their ability to abort the disease have been made.

¹ Read by invitation before the New York Dermatological Society, March 22, 1887.

The methods to which I refer are by irrigation with bichloride of mercury and the retrojection of hot water.

I have used the term urethritis in its broad sense, including thereby all varieties of urethral inflammation. That we may have here, as in other organs and tissues of the body, several distinct varieties, will now, I think, be generally admitted. Clinically, ever since the disease has been recognized, it has been observed that some cases present symptoms of great severity, while others run a comparatively mild course; the duration of the former is seldom under four weeks, and often prolonged indefinitely even under the most careful treatment, while the latter frequently disappears spontaneously in a few days.

The generally accepted belief among the profession that, in the first instance, the inflammation is caused by contact with a specific virus contained in the purulent secretion from the diseased organs of a person similarly affected, and that, in the second instance, the inflammation is produced by contact with irritating vaginal discharges occurring during menstruation or the course of a leucorrhœa, or that it is produced simply from mechanical irritation of a sensitive point in a previously diseased urethra, has led to general adoption, in the first case, of the terms *true gonorrhœa* or *specific urethritis*, and, in the second, of *false gonorrhœa* or *non-specific urethritis*. Further proof as to the belief in the specific nature of this virus is furnished by the general adoption of the term gonorrhœal ophthalmia for that distinct, virulent, often destructive and highly contagious form of conjunctivitis occurring in newly born children and others whose eyes have been exposed to contact with the purulent secretions of an acute gonorrhœa.

The strongest evidence in support of this view, however, is adduced from pathological rather than clinical investigation. Neisser, in 1879, after a large number of observations, pointed out that the pus from these severe cases of urethritis and conjunctivitis differed from other varieties of pus, by the presence in the former of a peculiar micro-organism which he called the gonococcus, and that in no other pus was this organism found. This statement has, during the past eight years, been confirmed by a large number of observers, so that now it may be safely said that none who have investigated the subject will undertake to deny the *constant presence* of this organism in these affections. Proof as to the exact etiological significance of this organism, which can only be furnished by carefully conducted

inoculation experiments, has until recently been rather unsatisfactory. This is owing, in the first place, to the extreme difficulty in its isolation and culture, and, in the second place, to the necessity of practicing these inoculations on the human subject, animals, so far as is known, enjoying an immunity from the disease. In the last edition of his work on the gonococcus,¹ Bumm gives three undoubted cases of acute characteristic urethritis resulting from inoculations upon healthy urethræ of gonococci from pure cultures of the second, fourth and twentieth generations; and I believe that any one who will take the pains to read a description of these carefully conducted experiments cannot fail to be impressed with their argumentative force.

In a recent article on the subject, Bockhart² gives the results of some interesting investigations on the non-specific, or, as he terms them, pseudo-gonorrhœal inflammations. He has observed fifteen cases of mild urethritis, undoubtedly infectious, in the secretions of which no gonococci could be found. The duration of these cases was short, recovery taking place in the longest in twelve days, and that, too, without treatment.

From a careful investigation of the secretions furnished by these cases, he was led to believe that the inflammation was caused by one of two distinct organisms, differing wholly in appearance and behavior from the gonococcus. This view was strengthened by further investigations, which resulted in the discovery of the same organisms in several instances in the vaginal secretions, alkaline in reaction, occurring in women as a result of menstruation, leucorrhœa and cancerous disease of the cervix. Proof as to the correctness of this view was furnished by some later experiments, which demonstrated that pure cultures of the above-mentioned organisms, when inoculated upon the mucous membrane of a healthy urethra, produced a urethritis corresponding in symptoms, severity and duration with the case from which the culture was taken.

In view of these facts, I think we are justified in holding that there are *at least* two varieties of acute urethral inflammation; that one is characterized by a relatively long period of incubation, severe inflammatory symptoms, redness and œdema of the meatus, marked dysuria and profuse purulent discharge, which, under ordinary treatment, continues for from four to six

¹ Der mikro-organismus der gonorrhœschen-schleimhaut-erkrankungen.

² Monatshefte für pract. dermatologie, 1886. No. 4.

weeks and often longer; that the other has often a relatively short period of incubation, mild inflammatory symptoms, moderate purulent or muco-purulent discharge, and which disappears often without treatment within two weeks; that these varieties can be distinguished, often by their symptoms, always by a careful microscopical examination of the discharge by a competent observer.

In estimating the value of any proposed methods of treatment, it is of the highest importance that this distinction should be recognized. That such differentiation has not generally been made is evidenced by the many methods of abortive treatment which have been recommended on the strength of one or two successful applications, and which have almost invariably proved ineffectual when applied to the severer forms of the disease.

It was in view of the probable bacterial origin of this disease that the methods of treatment to which reference has been made were undertaken. The first attempt at continuous irrigation of the urethra which I have been able to find was that made by Morgan¹ in 1862. His apparatus was similar in principle to the ordinary wash bottle of the laboratory. The efferent tube was connected by means of a rubber pipe with a conical glass nozzle, the afferent tube in the same manner, with a wooden mouth-piece. The nozzle was firmly pressed against the meatus, and a gentle current of fluid forced through the urethra by compressing the air within the bottle. The amount of fluid was so small (two ounces) that little benefit was derived from the use of this somewhat complicated apparatus. Dunham in Guy's Hospital Reports for 1870, and later Reginald Harrison, recommended the use of a retrojection apparatus, which consisted of a soft rubber catheter and an ordinary bulb syringe.

The catheter was introduced about five inches, and the urethra washed out from behind the supposed seat of inflammation. A moderate amount of medicated fluid was used, and the results, especially in chronic cases, were said to be satisfactory.

It was not, however, until 1883 that any attempt at thorough and continuous irrigation of the urethra was made. In the *Medical Record* for April 28th of that year, Dr. Holbrook Curtis published the results of his experiments in the treatment of acute urethritis by the prolonged retrojection of hot water.

¹ Dublin Quarterly, 1862

About the same time experiments were being made at Roosevelt Hospital by Dr. Wm. S. Halstead, which resulted in the adoption of a method of continuous irrigation with bichloride of mercury. In his original paper on the subject, Dr. Curtis refers to twenty cases of urethritis satisfactorily treated by his method, and states that he has yet to see the first case of acute gonorrhœa which will not yield to this treatment within two weeks. In an article which appeared in the *Medical Record* for March 27, 1886, Dr. S. O. Vanderpoel reported eight cases of undoubted acute gonorrhœal urethritis treated by irrigation with bichloride, in all of which recovery took place within two weeks. The results claimed for these methods were so much in advance of any that had previously been demonstrated that experiments to test their value were undertaken by a number of observers.

In my own investigations serious difficulties were at once encountered. The slight advantage which might accrue to the average dispensary patient from a rapid and complete recovery of an existing gonorrhœa seemed in no way to compensate him for the effort expended in making the necessary daily visits to the hospital and restraining his natural tendencies toward alcoholic and other excesses. Patients in whom cessation or marked diminution of discharge occurred, believing themselves to be well, would frequently suspend all treatment and remain away for several days, until a renewal of the discharge again brought them to the hospital. In this way much time was lost and the treatment unnecessarily prolonged. This irregularity in attendance and utter disregard of all instructions in nearly one-half of all cases which presented themselves for treatment precluded the possibility of any permanent benefit.

When, after the discharge had ceased and there remained only a slight moisture or mucous secretion, the treatment was changed from daily irrigation or retrojection to the employment of some mildly astringent injection, patients almost invariably discontinued their visits, so that only in a very small number of cases can it be said that recovery was absolute.

The object to be gained in irrigating the urethra by Dr. Halstead's method is to completely distend the canal with an antiseptic solution, and by means of the constant current of fluid wash away all products of inflammation. The apparatus necessary to accomplish this is an elevated reservoir, a rubber tube, and a glass or gutta-percha nozzle. (Fig. I.) I find the most convenient form of nozzle to be the double-current in-

strument devised by Dr. L. F. Keifer, an assistant in the genito-urinary room at Roosevelt, a description of which appeared in the *Medical Record* of April 9, 1887.

The patient is first instructed to pass his water, then standing in front of a sink or basin, the nozzle of the irrigator is firmly pressed against the urethral orifice. The current is so directed that the stream of fluid enters in the line of the canal, and not obliquely against the urethral walls. When this is accomplished, all that portion of the urethra anterior to the bulbo-membranous junction can be felt to be completely distended or "ballooned out." Sufficient outflow is now permitted to keep the fluid in motion while the urethra remains distended. From one to

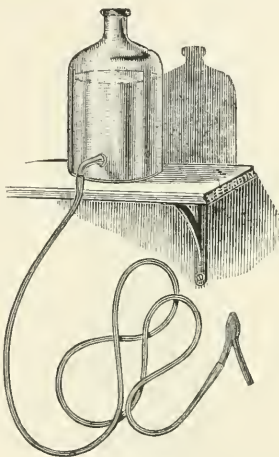


FIG. I.

two quarts of fluid are allowed to pass through the urethra at each irrigation. This should be repeated twice or three times during the twenty-four hours.

In hospital out-door practice this, of course, was impossible. The patients, however, were given a syringe and a quantity of the bichloride solution, and instructed to take three or four injections after each urination, and to report at the hospital every morning for irrigation. The strength of the solution used was from 1 to 60,000, to 1 to 10,000, according to the sensitiveness of each urethra.

As a result of this treatment it was generally observed, after the first twenty-four hours, that there was a marked diminution in the amount of discharge, with increased pain on urination. After two or three days the character of the discharge was

changed from a thick purulent to a thin muco-purulent or watery discharge. The number of gonococci would rapidly diminish, and their absence was generally noted after the discharge had been watery for two or three days. When this period was reached irrigation was discontinued and the patient

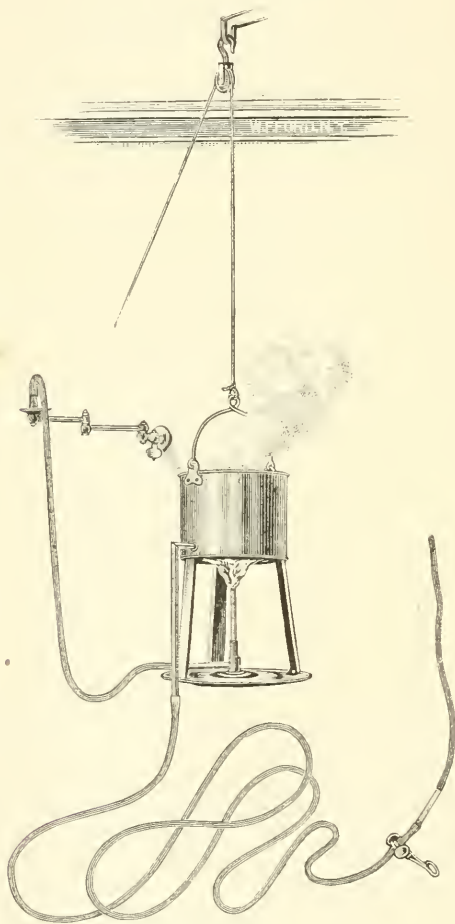


FIG. II.

instructed to use a mild injection of zinc sulphate, silver nitrate or bismuth suspended in glycerine and water. This was to be continued one week, during which time no discharge was, as a rule, noticed.

The apparatus employed in the method by hot retrojection consists in a tin pail, beneath which is fastened a platform for

an alcohol lamp or Bunsen burner. The pail is connected by means of a long rubber tube, with a No. 18 flexible catheter. The whole is suspended from the ceiling by means of a cord and pulley, and can be raised or lowered at will. (Fig. II.)

The patient, after having first passed his water, is seated on the edge of a chair over a large sized slop-jar or pail. The catheter, well oiled, is passed into the urethra about five inches and the current of water started. This is at first about the temperature of the body, but gradually raised until it is as hot as the patient can bear. About two quarts are passed through at each sitting. These should be repeated at least twice a day.

The result of this method of treatment with hot water alone, or combined with a small amount of tannin or sulphate of zinc, is to at once allay the inflammatory symptoms, lessen and modify the character of the discharge.

During the past six months the number of cases of urethritis treated at the out-patient department of Roosevelt Hospital was 212. Of these 139 were acute and 73 chronic. Of the acute cases 88 were classed as specific and 41 as non-specific or doubtful. Of the chronic cases 44 were classed as chronic purulent urethritis and 29 as gleet.

Seventy-seven were treated by irrigation with bichloride of mercury, 46 by hot retrojection; the La Fayette mixture was employed in 11 cases, while 7 received no treatment, but were kept under observation.

In explanation of the above classification, I will say that all cases in which the duration of the disease was under twenty-eight days were considered acute, and all over that period chronic.

Although the specific or non-specific nature of the process is now generally admitted to be determined by the presence or absence of the gonococcus in the secretion, in all cases which I have designated as specific the ordinary clinical symptoms of virulence have also been present. Gonococci were found in all so classed save two, and in those no examination was made, but, as both were primary cases, and presented all the characteristic symptoms of a specific urethritis, I have no hesitation in so classing them.

The following tables include all cases of urethritis (forty-five in number) treated by irrigation with bichloride of mercury in which the result was known:

CASES OF ACUTE SPECIFIC URETHRITIS TREATED BY IRRIGATION WITH
BICHLORIDE OF MERCURY.

PATIENT.	Duration.	Incubation.	SYMPTOMS.	Gonococci.	COMPLICA- TIONS.	Marked Improvement.	No Pus.	No Discharge.	REMARKS.
1. C. M..	21 d.	4 d.	Profuse purulent discharge; dysuria and tenderness at first.	.....	.....	3 d.	3 d.	..	.....
2. J. W..	28 d.	4 d.	Profuse purulent discharge; dysuria early.....	.....	.....	2	3	3	.....
3. C. H..	5 d.	2 d.	Profuse purulent discharge; red meatus; dysuria.....	Present.	.....	1	6	9	.....
4. W. H..	7 d.	4 d.	Profuse dischg.; edema of meatus and prepuce.....	Present.	.....	7	..	..	.....
5. J. B..	14 d.	8 d.	Disch'g moderate; dysuria great (copaiba erythema).....	Present.	Slight epididymitis on the 11th day of treatment	4	5	41	Treatment suspended for 2 weeks or more; contracted meatus.
6. J. B..	20 d.	7 d.	Profuse purulent discharge.....	Present.	.....	3	6	6	.....
7. C. H..	9 d.	4 d.	Profuse dischg.; dysuria.....	Present.	.....	1	..	..	.....
8. R. H..	11 d.	10 d.	Discharge and dysuria.....	Present.	Slight epididymitis, 10th day..	1	..	..	Very irregular.
9. J. P..	9 d.	5 d.	Dysuria and profuse purulent discharge.....	Present.	.....	1	22	39	Irregular; alcohol.
10. F. N..	7 d.	3 d.	Mod. discharge; dysuria.....	Present.	.....	1	12	..	.....
11. A. C..	1 d.	5 d.	Great dysuria; purulent discharge; lymphitis.....	Present.	.....	8	41	49	Contr'd meatus; divided during acute stage; sloughing.
12. M. L..	1 d.	9 d.	Profuse disch'g; red meatus....	Present.	.....	1	12	..	.....
13. W. W..	21 d.	7 d.	Dysuria at first; profuse purulent discharge.	Present.	.....	1	..	..	.....
14. H. H..	1 d.	6 d.	Purulent discharge; redness of meatus.	Present.	.....	1	..	..	.....
15. G. G..	2 d.	10 d.	Profuse brownish discharge; dysuria.....	Present.	.....	3	5	5	.....

CASES OF ACUTE SPECIFIC URETHRITIS TREATED BY IRRIGATION WITH BICHLORIDE OF MERCURY.—*Continued.*

PATIENT.	Duration.	Incubation.	SYMPTOMS.	Gonococci.	COMPLICATIONS.	Marked Improvement.	No Pus.	No Discharge.	REMARKS.
16. F. B..	14 d.	....	Profuse disch'g; dysuria.....	Present.	.....	1	18	19	Irregular; two speers.
17. J. C..	28 d.	....	Mod. discharge..	Present.	.....	1	6	10	.....
18. J. K..	1 d.	5 d.	Mod. discharge..	Present.	.....	4	12	12	Alcohol.
19. J. S..	1 d.	7 d.	Profuse disch'g..	Present.	.....	1	2	4	.....
20. J. E..	1 d.	6 d.	Mod. discharge; dysuria.....	Present.	.....	2	8	..	.....
21. C. B..	5 d.	3 d.	Dysuria; red meatus; mod. discharge.....	Present.	.....	1	8	11	.....
22. J. T..	14 d.	5 d.	Profuse disch'g; dysuria; redness.....	Present.	.....	1	..	..	.....
23. T. H..	9 d.	3 d.	Profuse disch'g; dysuria.....	Present.	.....	2	..	..	.....

CASES OF ACUTE NON-SPECIFIC URETHRITIS TREATED BY IRRIGATION WITH BICHLORIDE OF MERCURY.

1. J. J..	....	4 d.	Purulent disch'g.	.....	.....	1	1	1	.....
2. J. R..	2 d.	2 d.	Mod. disch'g. ....	.....	.....	1	2	2	.....
3. F. R..	21 d.	....	Mod. disch'g. ....	.....	.....	3	..	..	.....
4. P. H..	13 d.	....	Slight disch'g. ....	.....	.....	1	1	..	.....
5. J. T..	10 d.	4 d.	Purulent disch'g.	.....	.....	2	6	..	.....
6. P. C..	18 d.	3 d.	Profuse disch'g.	.....	.....	2	3	..	.....
7. A. W.	28 d.	3 d.	Purulent disch'g.	.....	.....	1	19	..	Contracted meatus.
8. J. M..	4 d.	5 d.	Considerable discharge.....	.....	.....	4	6	13	.....
9. R. S..	3 d.	2 d.	Mod. discharge..	.....	.....	2	3	..	.....
10. C. S..	7 d.	2 d.	Mod. discharge..	.....	.....	11	17	..	.....
11. J. C..	....	2 d.	Slight discharge..	.....	.....	3	4	..	.....
12. G. K..	2 d.	7 d.	Moderate purulent discharge.	.....	.....	1	3	..	.....
13. J. L..	21 d.	5 d.	Profuse disch'g.	.....	.....	6	..	..	Irregular.
14. J. D..	1 d.	5 d.	Dysuria; mod. discharge.....	.....	.....	8	11	..	Contracted meatus.

CASES OF CHRONIC URETHRITIS TREATED BY IRRIGATION WITH BICHLORIDE OF MERCURY.

1. J. R..	56 d.	....	Profuse purulent discharge.	.....	.....	1	1	3	.....
2. F. G..	210 d.	....	Profuse disch'g.	.....	.....	1	4	..	.....
3. G. F..	42 d.	10 d.	Profuse disch'g.	Present.	.....	1	11	..	Stricture at 1½ inch.
4. F. K..	49 d.	....	Purulent disch'g.	.....	.....	3	15	22	.....
5. G. J..	40 d.	....	Slight purulent discharge.....	.....	.....	1	1	1	.....
6. J. M..	308 d.	....	Slight discharge.	.....	.....	1	1	..	Contracted meatus.
7. M. W.	70 d.	....	Mod. discharge..	.....	.....	1	..	..	.....
8. J. C..	45 d.	....	Moderate purulent discharge.	.....	.....	1	9	..	.....

It will be observed that in the first table the duration of several cases was unusually protracted. The treatment in case No. 5 progressed favorably until the tenth day, when the patient, believing himself to be well, took an unusual amount of physical exercise, which resulted in a mild attack of epididymitis. All treatment of the urethra was suspended for two weeks. The discharge returned, but was quickly arrested by the further employment of irrigation. A slight watery discharge, however, persisted for a long time and was only checked after division of an abnormally small meatus. Case No. 10 was extremely irregular in his attendance and constantly disregarded instructions as to alcoholic indulgence. Case No. 11 had a contracted urethral orifice which so interfered with treatment that division was necessary during the acute stage. A severe lymphitis followed, with sloughing of the floor of the wound. Case No. 16 was entirely free from discharge at the end of three days' treatment. His supposed recovery was celebrated by the consumption of a large amount of beer. The discharge returned and continued during an irregular course of treatment until the nineteenth day.

Of the twenty-three cases of acute specific urethritis treated by irrigation with bichloride of mercury, marked improvement was earliest noted on the first and latest on the eighth day. Sixteen of these continued until all purulent discharge had ceased and were practically well. This occurred earliest on the second and latest on the forty-first day. Average cessation of purulent discharge in $10\frac{9}{10}$ days. Twelve continued to report until there was absolutely no discharge. This was noted at the earliest on the third and latest on the forty-ninth day. Average cessation of all discharge in $17\frac{1}{3}$ days. If, however, we exclude cases five and eleven as rare and unusual, the average duration of treatment in the remaining ten cases would be $12\frac{1}{2}$ days.

Of the fourteen cases of acute non-specific urethritis, marked improvement was earliest noticed on the first, and latest on the eleventh day. Absence of purulent discharge, earliest on the first, and latest on the nineteenth day. Absence of all discharge, earliest on the first, and latest on the thirteenth day. The averages in this class are: improvement, $3\frac{4}{14}$ days; absence of pus, $6\frac{1}{7}$ days; absence of all discharge, $7\frac{3}{4}$ days.

Of the eight cases of chronic purulent urethritis treated, marked improvement in seven was noticed at the end of the first twenty-four hours, and in the remaining case at the end of three

days. Average cessation of purulent discharge on the sixth, and average cessation of all discharge in $9\frac{2}{3}$ days.

Complications were of very rare occurrence. Slight frequency of micturition was noticed in two or three cases, which would disappear by omitting the treatment for a short time.

Two cases of very mild epididymitis occurred, one on the eleventh and the other on the thirteenth day of treatment. The first was directly traceable to an unusual amount of physical exertion. For the second no cause could be ascertained. As both had shown marked improvement during the treatment which had been faithfully carried out for nearly two weeks, the complications can hardly be said to have resulted from the irrigation.

The results which I have obtained by this method are, I think, better than any which have heretofore been reported in a similar class of cases where the distinction was drawn between gonorrhœal and other forms of urethritis.

In private practice the results are still more favorable. I have been able to collect thirty cases occurring in the private practice of Drs. S. O. Vanderpoel, E. R. Chadbourn, Frank Hartley and F. H. Markoe, all of undoubted acute gonorrhœal urethritis, in the secretions from which gonococci were found, which were successfully treated by this method. In all of these recovery took place within two weeks. The average date of recovery in the thirty cases being in $7\frac{2}{3}$ days.

So much time has already been consumed that I shall but briefly refer to the results which have followed the retrojection of hot water, a method of treatment which to my mind has not received the attention it deserves.

It was my original intention to make a series of experiments in which the influence of hot water alone, of hot water combined with the various mineral and vegetable astringents, and of hot water in combination with bichloride of mercury, could be determined in each of the several varieties of urethritis. It will be understood, however, that to accomplish this result a large number of experiments would be necessary, much larger in fact than it has been my privilege thus far to make.

By careful observation, however, of forty-six cases treated by this method, I can say that the prolonged retrojection of hot water alone, or combined with some astringent agent, in all cases of urethritis where it can be successfully employed, causes at once a marked abatement of the inflammatory symptoms, a diminution in the amount of discharge, and a decided change in

its character ; that this alone is often capable of entirely checking the discharge in cases of non-specific and chronic urethritis within a very few days ; that in several cases of acute specific urethritis, in which this plan was carried out for several weeks, no marked curative effect was observed ; but that in the retrojection of a hot solution of bichloride of mercury we have a method which combines the soothing and antiphlogistic action of heat with the germicidal and curative effect of the bichloride, and which, in cases of acute specific urethritis, fulfills the indications in a more satisfactory manner than any method with which I am familiar.

In regard to complications. There is a general impression among the profession that the ordinary inflammatory complications of urethritis, viz., epididymitis, cystitis, and prostatitis, are more frequently observed in cases treated by the retrojection of hot water than in those treated by the ordinary methods. In the forty-six cases which I have treated by this method and which represent more than 300 applications of hot water, no inflammatory complication has occurred. The only suggestion of a complication was slight pain occurring over the region of the spermatic cord in one case, and which quickly subsided on the application of mild counter-irritation.

In conclusion, I think it may be fairly stated :

First.—That in un-complicated cases of acute gonorrhœal urethritis, treated by prolonged and frequent irrigation with bichloride of mercury, recovery may be expected within two weeks ; that this period may be considerably shortened by the early inauguration of treatment, by absolute rest, and by the avoidance of stimulants ; that it may be indefinitely prolonged by irregularity in treatment, by inordinate physical exertion, and by indulgence in alcoholic and venereal excesses.

Second.—That the retrojection of a hot solution of bichloride possesses all the advantages of the former procedure, and in addition causes a more rapid subsidence of the inflammatory symptoms, a greater feeling of comfort to the patient, and is attended with less annoyance and trouble.

Third.—That in cases of acute non-specific urethritis, the favorable influence of each of these methods is strikingly apparent.

Fourth.—That in cases of chronic purulent urethritis, no agent produces such rapid and permanent improvement as irrigation, especially when combined with astringents and heat.

Fifth.—That the percentage of complications occurring in cases treated by these methods is far below that observed when the ordinary methods are employed.

29 WEST THIRTIETH STREET.

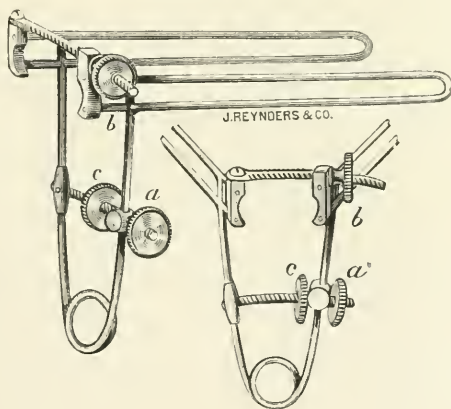
A NEW URETHRAL SPECULUM, WITH CASES ILLUSTRATIVE OF ITS USE.

BY

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THE following cuts will illustrate a urethral speculum designed by myself and manufactured for me by Messrs. Reynders & Co. in the fall of 1883. The instrument was devised to treat some cases of intra-urethral condylomata which were then under my care. Since that time I have used it



in a large variety of urethral affections with the utmost satisfaction; and, after testing several modifications, I now present it to the profession for what it has been to me—a very useful instrument.

The upper cut represents the instrument with the blades separated parallel. The lower cut shows how the deeper portions of the urethra may be distended with very little stretching of the meatus.

The instrument was suggested to me by Dr. Bosworth's nasal speculum; but in its simple form, without the thumbscrews *a*, *b* and *c*, it was open to two objections, viz.:

First.—If the spring were strong enough to distend a urethra of large calibre it would be painful in smaller ones; in fact, in a majority of cases.

Second.—If the blades were over one inch in length the elasticity of the urethra would press them together at their ends, twisting the upright bars on themselves and showing only the first inch or inch and a half of the walls. To overcome these objections an instrument was devised, which may be described as follows:

The blades are $3\frac{1}{4}$ inches long and $\frac{1}{4}$ inch wide, fenestrated and polished, so that it is almost painless on introduction into the most tender urethra—a small injection of 4 per cent. solution of cocaine just before using makes it entirely so.

The thumbscrew *b* upon a curved bar regulates the instrument to the width of the meatus. The screw *a* controls the spring and prevents too sudden or too great distension; while the screw *c* effects a forcible separation of the blades when the spring is too weak to accomplish this.

The instrument is introduced its full length closed, and the screw *b* gradually run out to almost the capacity of the meatus. The upright bar on the right-hand side will then be resting against the screw *a*. This screw is then run slowly out and the bar, impelled by the force of the spring below, follows it, separating the *ends* of the blades rapidly while the bases are only slightly moved. The motion is that of two equal radii starting from the same point and each describing the arc of a circle in opposite directions; the proportion between the distension at the meatus and that at the ends of the blades being about 1 to 12.

By this mechanism one is able to obtain a view of the whole wall throughout the anterior $3\frac{1}{2}$ inches of the urethra, for the distension gives a view of $\frac{1}{8}$ to $\frac{1}{4}$ inch beyond the ends of the blades.

The value of such a view will be appreciated by all who do any amount of genito-urinary practice.

My thanks are due Mr. Lincoln, of Reynders & Co., for valuable assistance in carrying out my designs.

Illustrative of the use of this instrument, I may mention some cases in which it has proved of service to me.

W. F., æt. 24, Hebrew, had for several months, following a

protracted gonorrhœa, a persistent muco-purulent discharge. Injections and anti-blennorrhagics controlled it while they were used, but upon their discontinuance it invariably returned. Examination with the meatoscope $1\frac{1}{4}$ in back revealed no cause for it, but the speculum showed $1\frac{3}{4}$ in back three flat, non-pedunculated tumors, evidently condylomata, whitish in color, smooth in surface, and producing an itching and desire to urinate upon being touched. Applications of glacial acetic acid followed by the insufflation of a powder of Zinc Ox and Hydrarg Chlor. equal parts, removed the growths in less than ten days, and the symptoms have never returned.

W. H. J., æt. 48, was treated by me for an acute gonorrhœa which yielded kindly except one little drop of pus persistently appeared two or three times a day. Injections of all sorts were used to no effect. An examination with the speculum showed the discharge to proceed from the lacuna magna, into which I introduced a probe coated with crystallized nitrate of silver. After two applications the discharge stopped, and patient has remained cured till to-day, over three years.

One case more. Mr. P., who had been troubled with chronic gleet for many months, consulted me in regard to it. I located a stricture two inches from meatus, calibre 26 F.; urethral calibre 32 F. I operated for same with perfect success, but the discharge, though lessened, continued in spite of injections, antiseptics and otherwise. I may say here that I have been much disappointed in the use of the former class of remedies in gonorrhœa. They have done little if any good in my hands or those of my friends, and I do not think their most enthusiastic advocates can show any better records from their use than have been obtained by other methods. But to return to my patient. An examination with the speculum showed the line of the stricture distinctly and the linear cicatrix of the incision. Behind the stricture was a bright red elevated spot of granulations with glassy surface, produced by the serous discharge. These proved stubborn at first, but after about four weeks' treatment they healed over, the discharge ceased, and the patient has been quite well ever since, as well as quite grateful.

It is useless to multiply these illustrations. Any one familiar with this class of practice will appreciate its value in intra-urethral chancres, chancroids, follicular degenerations, etc., and I hope the instrument may be as useful in the hands of the profession as it has in my own.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

171ST REGULAR MEETING.

DR. ROBT. W. TAYLOR, *President, in the Chair.*

DR. SHERWELL presented a case of

MYXEDEMA

with the following history :

Augusta S., æt. 33, Germany, 11 years married, 5 children, 2 living, 3 having died from children's diseases. No miscarriages. Had suffered from nasal catarrh as a child, but, apart from that, had always been exceptionally healthy up to March, 1886 ; at about the middle of that month was attacked with what was diagnosed as erysipelas of head and face, extending afterward upon scalp ; then suffered from cerebral and meningeal symptoms, and was more or less delirious and unconscious for a fortnight (she was at the time gravid about middle of fifth month, and was at the end of natural term delivered of a healthy boy, he still continuing so). The symptoms abated in gravity after the time named, when she became apparently perfectly well, the only thing left being a tumefaction in and under skin, just in the location of present site of trouble. She came under my notice first at my clinic at Eye and Ear Hospital, January 7, 1887. On examination the skin over frontal bones in the median line and taking up the whole ground between eyes was of an œdematous appearance, but more circumscribed and different in texture and feel to an ordinary œdema, both upper and lower lids in both eyes (more especially the right) presenting the same appearance and feel, the same characteristic apparent puffiness, but of more resilient character, extended down on both cheeks, here too more particularly on the right side, color natural or even slightly exaggerated, but not erythematous, rather of a waxy, clear tint, in fact very much as she now presents herself, the diagnosis then made was of lymphadenoma or lympho-sarcoma, but am inclined now to consider it a myxœdema.

All treatment used has been of an alleviative nature constitutionally, and of a resolvent, a mild hydrarg-præcip alb. unguent locally, and sprays of a mild Lugols sol. to nares. Treatment seemed to benefit for a time, then stationary, now advancing and extending down to angle of jaw.

DR. ELLIOTT presented a case of

TROPHONEUROTIC AFFECTION OF THE NAILS,

the history of which was as follows :

Patient C., age 22, was referred by Dr. L. M. Yale to the New York Skin and Cancer Hospital for treatment March 9, 1887.

The affection from which he was suffering had begun six months ago under the form of a brownish, painless spot which appeared about the central portions of the nails of the ring finger of each hand. They increased in size and the other nails became also affected, but the progression of the changes was slow. When examined, the nails of all the fingers, with the exception of that of the index finger of the right hand, were found to be dis-

colored, brownish in color, only slightly striated longitudinally, dry, not very brittle, and separated from their beds for about two-thirds of their extent. The last phalanx of all the fingers, except that of the already mentioned index, were bulbous, enlarged and bluish red, cold and clammy to the touch. Patient was very nervous, easily excited, and while being examined would begin to tremble and break out in cold perspiration. Pulse compressible and variable; at one time sixty pulsations to the minute; again 100 and 120. No history of trauma or severe disease preceding process; nails examined microscopically, excluded onychomycosis. From the symmetry of the changes and the exclusion of all possible causes, the diagnosis of atrophica unguium trophoneurotica was made. I sent him to Dr. W. Allen Starr for examination, from a neurologist's point of view. He answered that owing to the symmetry of the occurrence, the associated vaso-motor condition, and the absence of any sensory symptoms that the cause was not peripheral, but central, probably in the first dorsal segment of the cord. He admits that at present the diagnosis of the changes there must be hypothetical, but thinks they are possibly of the nature of a beginning syringo-myelitis, situated in the gray matter next to the central canal of the cord.

DR. ELLIOTT presented on behalf of DR. BULKLEY a case of

DERMATITIS HERPETIFORMIS.

Name, Jacob B—; age, 26; American; single; a blacksmith.

Patient states that he never was sick in his life until in November, 1885, at which time pruritus began in the soles of the feet, accompanied by swelling of the legs. He states that there were no lesions upon the skin of any sort, but this can be taken with reserve owing to the fact that at present he says the same thing, notwithstanding that lesions are to be found here and there over the body. The pruritus progressed, until by January, 1886, it extended over entire body. It was very intense and persistent. In January, 1887, alopecia and fragility of the hair of the head, pubes and axillae, in fact, of entire surface was manifested. His health at present is poor and he has lost much in weight. When admitted to Dr. Bulkley's service, in New York Skin and Cancer Hospital, there were scarcely any new or fresh lesions seen. There were around the loins and back, on the legs, the remains of lesions, as evidenced by hard, slightly reddened spots, but no vesicles or pustules were present. The hair everywhere was found thinned and broken, showing only short stumps projecting above surface. Since then a few new lesions have appeared, consisting of vesicles situated upon a broad, elevated, reddened base. No distinct grouping is, however, to be found, yet the majority of the new spots are aggregated upon the head and back of neck. The pruritus is still intense, but the patient's general health is much improved.

The discussion of these cases was postponed until the next meeting.

DR. BREWER, by invitation of the President, read the paper of the evening, entitled

SOME OBSERVATIONS UPON THE MODERN TREATMENT OF URETHRITIS.¹

In the discussion which followed,

DR. E. C. WENDT said: Mr. President, I fully agree with the reader of this highly interesting paper in everything he has said with regard to the necessity for an examination of the secretions for the presence of gonococci, and in that way differentiating between at least two forms of catarrh of the urethra.

¹ See page 170.

One is a specific and virulent catarrh, evidently due to these micro-organisms. The second may be called a benign catarrh, and is not, in my opinion, due to the presence of micro-organisms, in spite of the contrary observations of Bockhart, cited by the reader of the paper. I think Bockhart's microbes were merely accidental. Dr. Allen has so recently published a paper in the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES which embodies some of the results obtained by him and myself during the past three years that it is hardly necessary in this connection to allude to more than one point which the reader has not brought out, and that relates to the differentiation between real gonococci and morphologically similar organisms. I attach much value to this point and I think we must welcome the method of Roux as giving us additional means of identifying organisms which appear to be gonococci. It is, for example, quite possible that in some of the cases which Dr. Brewer has mentioned, there may have been ordinary harmless diplococci. For with the microscope alone, without the application of Roux's test, we are not always able to distinguish the true gonococci from other bacteria devoid of special significance.

With regard to the value of his two methods of treatment, there is no gainsaying that the results which Dr. Brewer has announced are highly satisfactory. Of course they will need confirmation at the hands of others. Quite a number of similar experiments have been made by others, and their results have been far less satisfactory than those of the reader of the paper. Arguing in a somewhat theoretical way we must, I think, take into account that the gonococci (which evidently cause the disease as shown conclusively by Bumm) are not merely found on the surface of an inflamed urethra, but that they penetrate the epithelial layers and get pretty far down into the deeper structures of the urethra. I do not see how any kind of injection can act upon them there. As Virchow has pointed out, there will always have to be a fight between the protoplasm of the cells and these micro-organisms themselves. Now it is a well-known clinical fact that those individuals whose protoplasm is presumably in excellent condition will get over an attack of true gonorrhœa much sooner than those whose protoplasm is vitiated by any cause whatsoever. You have all had patients who have used every kind of injection, but were made worse by these injections instead of better, simply because ordinary hygienic measures were not carried out, and their general health was poor.

I think the time will come when we will use much less local treatment and try to assist nature to eliminate the gonococci by building up the protoplasm of the individual in every way, and giving the inflamed parts absolute rest, so far as that is possible. I am inclined to regard the methods of treatment which Dr. Brewer advocates heroic and in many cases too heroic. I should hesitate especially to employ them in the very early stage, as the Doctor has done. I think if we had ten times the number of cases he has observed to compare with an equal number of cases treated by letting the urethra entirely alone, *i. e.*, making no injections at all, the results in the latter class of cases would be found to be at least equally good—using, of course, some internal remedy. It has been proven that the old-time remedies, cubebs, copaiba and sandal, will, by the time they reach the bladder, have formed certain compounds which are hostile to the gonococci. These drugs act in two ways. First through the blood and then through the urine. And they can accomplish, in my opinion, in an antiparasitic way probably as much as the heroic injections used by the reader of the paper. Moreover, these injections may be carried out in dispensary and hospital practice, but I doubt whether they will ever become very popular in private practice. I have attempted to enforce them, but met with too much opposition on the part of patients, so that I had to give them up.

To repeat, I think it is of extreme importance in every case before making a positive diagnosis to examine the secretions microscopically, and in those cases which are in any way doubtful apply the color test of Roux.

DR. MORROW.—Mr. President, I have but little practical familiarity with the methods of treatment advocated by the reader of the paper. In view of the fact that the subjects of these experiments were, for the most part, dispensary patients, and the treatment was carried out under the unfavorable conditions inseparable from out-door practice, his statistics are certainly most satisfactory.

Notwithstanding the favorable results claimed for the antiseptic treatment of gonorrhœa, I am somewhat skeptical as to its superiority over the older methods of treatment. I am still disposed to agree with Milton, who stated in his Treatise on Gonorrhœa, ten years ago: "I doubt whether man will ever discover drugs superior in their power over this disease to those we already possess." Judged by the test of treatment alone, I think it must be admitted that the theory of the microbial origin and nature of gonorrhœa has not been sustained.

I by no means wish to place myself on record as an opponent of this theory. Microscopical evidence of the existence of microbes in the products of urethral inflammation is complete and conclusive, but that the gonococcus is the exclusive pathogenetic factor—the sole agency by which gonorrhœa is propagated from one individual to another, and that its presence or absence constitutes the test of the severity, the duration and the infectious quality of a discharge—I do not unqualifiedly accept. This etiological relation has not been definitely proven. I would take issue with the author of the paper in his statement that we can differentiate a "specific" from a non-specific urethritis by the severity or mildness of the clinical features. I think all authorities agree that a urethritis having its origin in a menstrual or leucorrhœal discharge, for example, is often characterized by the intensity of its symptoms, prolonged duration and obstinacy to treatment. The intensity of the urethral inflammation, its persistence, and other characters, depend largely upon anatomical peculiarities of the individual mucous membrane, a damaged condition of the urethra from antecedent disease, and other conditions which pertain to the individual rather than the exciting cause. I may further say that there are certain facts in the natural history of gonorrhœa which I cannot satisfactorily reconcile with the theory of its microbial nature. I may briefly refer to its often spontaneous limitation to three or four weeks, the development of gonorrhœal iritis, and other complications, especially epididymitis, the subsidence of the discharge into a mucoid or gleet condition, which may persist for months or years and then suddenly develop into a profusely purulent discharge, swarming with microbes. It may be asked into what inaccessible retreats do the gonococci retire during these periods of latency, and how are they thus suddenly stirred up and awakened into activity.

If we accept the parasitic theory of gonorrhœa, we should *a priori* conclude that the abortive treatment would be always indicated and uniformly successful; the parasite should be promptly destroyed and its contagious elements annihilated. Practically, however, we find that most of the advocates of this theory, defer the use of injections until after the subsidence of the acute inflammation, when the tissues are swarming with microbes and the inflammation is no longer confined to the anterior urethra. Aubert, a most ardent gonococcist, declares that he does not know of a single case of recent gonorrhœa, where the diagnosis has been established by the microscope, in which the abortive treatment proved successful.

There seems to be no unanimity of opinion in regard to what constitutes the most efficient parasiticide. Neisser uses nitrate of silver and salicylate of sodium, while rejecting as inefficient solutions of the bichloride. Again, the strength of the solution requisite to kill the microbes does not seem to have been definitely determined. From the experiments of Ecklund and others it would appear that the solutions of the bichloride usually employed have absolutely no parasiticide effect.

In regard to "hot water irrigations" I may say that I was disposed to think favorably of this form of medication after reading Dr. Curtis's article in the *Medical Record*, but the unfortunate experiences of Dr. Keyes and others, who had experimented with this treatment, and which were reported in a discussion before this Society some three years ago, led me to reject it as inefficient and unsafe. It is fair to assume, however, in view of the favorable results reported by others, that this treatment may have been injudiciously used in the cases reported by Drs. Keyes, Otis and others.

It seems to me that, as yet, there has been no antiparasitic treatment discovered which will destroy the parasites without also proving injurious to the tissues in which they find lodgment, and for that reason the use of antiseptic injections does not constitute a real advance in the treatment of gonorrhœa.

DR. SHERWELL.—Mr. President, in general I coincide with the objections offered by Dr. Morrow, who has expressed them in better form than I could do. For instance, I agree with him in his doubts regarding the microbian origin and perpetuation of gonorrhœa. While I do not pretend to deny, any more than does Dr. Morrow, the possibility of such parasitic origin, still I am inclined to doubt it, as I doubt it with regard to other diseases. The fact of not proven comes up all the time. But I am willing to accept proof when it shall come.

Two clinical facts were impressed upon my mind during the reading of the histories of the cases. First, the discharge had stopped in one day in two or three of the cases in which hot water was employed. This is extraordinary; it is phenomenal. It is so extraordinary that I should think it was possible there had been some error in the diagnosis. But I have not tried the method, and therefore I should not doubt it. Second, how many cases were treated by rest alone, and was this element considered at all in the treatment? Of course we all recognize the importance of rest in the treatment of gonorrhœa, but I believe the author of the paper did not dwell upon it. I had considerable experience in the treatment of gonorrhœa in my earlier practice, and I would rather undertake to cure a man with absolute rest than by any system of medication, perfect rest in bed, I mean. But we know how hard it is to get that in cases of gonorrhœa. Still, rest is an important factor in the treatment of all cases, and should always be taken into consideration in estimating the results.

DR. PALMER, of Louisville, Ky. (by invitation).—Mr. President, I must confess that I am very much of a skeptic. I have used injections in gonorrhœa six months or a year with varying results. In most cases the results were unfavorable. I have employed all methods of injection which have been suggested, excepting this new double tube which Dr. Brewer employs. I have not liked bichloride solutions at all. I have rather preferred boric acid in saturated solution. But my conclusions, based on the treatment of a number of cases by injections, are that the ordinary course of gonorrhœa will not be much curtailed by such injections. Finally I may say that my tendency has been more and more toward internal treatment judiciously applied, supplemented by such local treatment as we have been accustomed to.

DR. F. R. STURGIS.—Mr. President, it is difficult to criticise a theory or a mode of practice unless one has had considerable personal experience as a basis for his remarks.

In the first place, with regard to the cocci theory, I must confess that I have been rather unfortunate in my search for the gonococcus, so that I am becoming rather skeptical as to its being the actual cause of gonorrhœa. I think it is unfortunate to use the terms specific gonorrhœa and non-specific gonorrhœa, because an element of confusion is imparted to the subject thereby. It seems to me far better to speak of it as acute, subacute and chronic urethritis.

As I understand the advocates of the germ theory, it is claimed that the

gonococcus is present in all cases of gonorrhœa. Now, you get a case of what appears to be true gonorrhœa; all the symptoms of gonorrhœa are present—an abundant discharge, ardor urinae, a history of impure connection, yet no gonococci can be found, and the advocates of the germ theory tell you that if there are no gonococci there is no gonorrhœa. I think that is begging the question. From Bunum's last article it would seem that these micrococci are present not only in the pus but in the epithelial cells. His cases are based on snippings from the conjunctival mucous membrane of purulent conjunctivitis, claimed by him to be due to gonorrhœa, but which, from the text, does not appear to me to be conclusively so. Regarding my own experience in searching for the gonococci, I may say that my attempts have not been crowned with success. In some cases I have found them, but in the larger proportion of cases of urethral discharge I could not find this microbe. I therefore occupy about the position of Dr. Morrôw. I think it is a case unproven.

With regard to treatment, I do not believe that at present we have anything better than the old-fashioned sulphate or acetate of zinc. Dr. Holbrook Curtis, before he published his paper, or very shortly afterward, was good enough to call my attention to his method. He and I went to Charity Hospital and tried it. I used it persistently there, and in dispensary and private practice, and in some cases it acted charmingly; in other cases it did not act at all. In fact, sometimes it did more harm than good. Dr. Curtis was then using, I believe, iodoform, tannin, and glycerine in solution. I tried that method, also the use of corrosive sublimate, etc., and I afterward came to the conclusion that in the early stage of a clap, before the discharge has become purulent, it is a very good form of treatment, but if it is employed during the purulent stage, it will do absolute harm. I remember one case in which the discharge from the urethra was only of twelve hours' duration; it was thin and glairy. I used hot water and iodoform injections, as suggested by Dr. Curtis, and within forty-eight hours the man was well. I kept him under observation for ten days, and there was no discharge. He had no discharge for some months afterward, when he came back again with a little discharge, and I tried the same injections. But the disease progressed. Finally, he had to use the sulphate of zinc, and then he got well. Here was an experience with the same patient in two different instances. This was before the microbe theory came up, and the gonococcus was not looked for.

With regard to corrosive sublimate injections, I have found that few patients will stand more than one in ten thousand. In stronger solutions, say one in five thousand, it causes pain. If Neisser's opinion is correct, that the microbe is within the cell itself, I do not see how the injections will do good. I do not see how internal treatment by cubebs and copaiba will do any good by acting as parasitocides, for they are not parasitocides.

DR. WENDT.—When they enter the urine they become chemically changed, and in their new form are parasitocides.

DR. STURGIS.—I do not think that has been proven. These low organisms will live through a great deal of antiparasitic treatment, and it must be a strong solution to do any good.

I protest against the French method of letting a clap alone, because it means that stricture will almost surely follow. I think the quicker we commence treatment, the quicker a clap will get well. Much depends upon the directness of treatment and the thoroughness with which it is carried out. Many cases of clap continue because the patient does not know how to inject himself. And the surgeon may not know. If we can put the patient to bed he will get well within two weeks, but if he is treated as an ambulant case, the disease may last several months.

With regard to deep injections, it is a question in which I have been interested for some years. Dr. Curtis and I went to the Island two or three times together, and employed them, and later I tried them alone, but seldom

with benefit. I do not think they are productive of as much good as has been claimed, and in some instances I think they cause positive harm.

DR. W. S. HALSTED.—Mr. President, I cannot resist making a few remarks now because of the general skepticism of the gentlemen who have so fully discussed the paper. I thought just as they do at one time. I know they will think as Dr. Brewer and I do finally. I experimented in Roosevelt Dispensary at least two years with various methods, conscientiously, before I tried what I dislike to hear called the corrosive sublimate method—the injection of very mild solutions of corrosive sublimate, varying from 1.40000 to 1.60000, sometimes 1.100000, so mild indeed that the patient can scarcely tell whether anything stronger than water is being used. I may say at the start that in all the cases I made examinations of the secretions under the microscope, for I am a firm believer that the gonococci are the cause of the disease. During my experiments the most common injection which I employed was iodoform ointment. I attended the Dispensary every day, Sundays included, and if a patient was absent two days I refused to treat him any longer. Every morning when the patient returned, some of the discharge was examined under the microscope to determine whether the number of organisms had diminished, and it was noted whether the general condition of the patient was improved. I used iodoform ointment in this way, also bismuth, glycerine, acetate of lead, sulphate of zinc, boric acid, salicylate of soda, carbolic acid, and nitrate of silver solutions in varying strength. These we tried faithfully for a number of weeks, iodoform ointment for some months.

In two years and a half I did not succeed in aborting a single case of gonorrhœa, and I had given the thing up, and when anybody had a method to recommend, I was just as skeptical as it was possible to be. The method employed by Dr. Brewer suggested itself to me in connection with the treatment of abscesses in hospital practice. If you inject an acute abscess cavity with large quantities of a very weak solution of corrosive sublimate it will heal up much sooner than if you inject less frequently a small amount of a stronger solution. So it occurred to me that there might be an area of rapid production of bacteria in the immediate neighborhood of the free surfaces of the abscess which could be reached by the larger injections. At any rate it is well known that the bacteria are most rapidly produced near the free surface of the abscess.

I applied this method to some hospital gonorrhœal cases, but without success, because they were irrigated only once a day, and sometimes the patients did not return. Then I tried it in six cases in private practice. All were aborted; no case, as far as I can remember, running longer than ten days, and one or two of the cases a much shorter time. Dr. Vanderpoel has also treated some private patients in this way. The treatment extended usually over six or seven days, but the discharge may have ceased on the second or third day. There might remain a drop of the secretion in the morning, or slight moisture during the day. This was a great surprise to me. One of my patients told me afterward that he had taken wine throughout the treatment, and exercised as he chose. On the strength of that I allowed another patient to drink during the treatment, and he got well just as quickly as the others. That was a complete revelation to me.

I told several doctors of this method, and some of them have told me that they were sorry to have learned of it, because their income from that source was now virtually at an end. The patient would come two or three times at most. Then he gave his prescription to his friends also. Frazer puts up a tablet of corrosive sublimate, of a size sufficient to make a solution of the proper strength when dissolved in perhaps a pint of water, and these are well known among club men in New York who have become accustomed to treat themselves. One of my patients so treated got gonorrhœa again in California, and he wrote me that he recalled my method of treatment, and adopted it with equal success there, recovering in a few days. I am thor-

oughly convinced of the efficacy of this method of treatment. In private practice I have not had a single failure. In every case the gonococci were found.

DR. HALSTED said he was a firm believer in the microbial origin of gonorrhœa, and he had never failed to find the gonococci in a well-established case. A case going to prove the value of the presence or absence of the gonococcus in the diagnosis of urethral discharge was cited, it being that of a man who came with two others, the latter having true gonorrhœa with gonococci present. The former, although having had a discharge two years, and treated by eminent specialists for gonorrhœa, was found to have not true gonorrhœa, the gonococcus being absent. Dr. McBride took charge of the case for him, treating it as one of gouty urethritis, and by regulating the diet the man entirely recovered.

DR. H. HOLBROOK CURTIS.—Mr. President, in 1882 I conceived this idea of hot water retrojection. I called it progresso-thermal retrojection because the heat was increased until the point of tolerance was reached. I experimented with carbolic acid, borax, bicarbonate of soda, sulphate of zinc, tannin, iodoform, and various ingredients, and came to the conclusion finally at the end of a large number of cases (I think I treated a hundred cases during my experiments in that disease), that it was of little importance what ingredient was used as long as it was either an alkali or acid. I discovered very soon that retrojection with intensely hot water alone was injurious, as it caused the urethral epithelium to swell, and I stopped it. My best results were obtained with very weak solutions of sulphate of zinc, boracic acid, or bicarbonate of sodium. At the time I wrote the article quoted I had seen probably twenty-eight cases, and I am very loath to think that they were all non-specific. I think the longest that any case ran was sixteen days; the majority of the cases were cured in less than two weeks. This without the use of bichloride of mercury. I used the bichloride later. At that time the gonococcus had not been satisfactorily isolated. In one case I used the bichloride in solution stronger than one in five thousand, and caused the patient extreme pain, but it entirely cured his gonorrhœa in two days. Out of more than one hundred cases which I have treated by retrojection I have not caused epididymitis or orchitis in one. Epididymitis occurred in two of the cases, but it could be traced to other causes than the retrojection. Dr. Keyes strongly attacked the method shortly after the publication of my paper; he was so caustic in his criticism and had such bad results from the four cases he cited as having been treated by the hot water method, that it was the means of temporarily stopping further experiments by the profession. His bad results were undoubtedly due to a misconception of the theory of retrojection and an imperfect use of the apparatus. Since the specific theory has been positively decided I have combined the soothing effect of hot water with the germicidal effect of the bichloride of mercury, and as a result I am convinced that the perfection of treatment thus far has been attained.

DR. KIEFFER showed two nozzles with double channels for use in irrigation. The more recent had a flattened orifice for better fitting the meatus.

DR. ALLEN.—Mr. President, I have recently stated my belief that with the perfection of methods of applying antiparasitic remedies our results in the treatment of gonorrhœa will be much more satisfactory. I have also said that it would appear that complications are not now so frequent in gonorrhœa which is treated by these newer methods as they formerly were, and I am very glad to hear from the reader of the paper, and from Dr. Halsted and Dr. Curtis as well, that the number of complications in their cases treated by retrojections has been so small. It surely shows an advance in the therapeutics of gonorrhœa. It seems to me that in gonorrhœa there really is no period of incubation. As soon as the pus containing gonococci gains access to the urethra or vagina the disease already exists, and if we can apply our antiseptic treatment at once,

I do not see why the disease cannot be aborted instantaneously. A day, it seems to me, is long enough for treatment, and I am not at all surprised that the gentlemen who have been fortunate enough to have a case under their care at the very onset have succeeded in aborting it within twenty-four hours. As a rule, when a case comes under our observation the disease has already been in existence at least three or four days; the gonococci have multiplied and perhaps permeated the tissues; there is abundant pus; the disease has a firm hold, and it is difficult to abort or cure it.

The classification of gonorrhœa which Dr. Sturgis would make, it seems to me, is an unfortunate one. If the term specific is objected to, another one might be found; but there should be some term to indicate that we recognize two forms of urethritis—a urethritis due to a microbe which we know and can recognize, and a urethritis in which this microbe does not appear. In many examinations of pus from about 250 cases of urethritis I have been able to find the gonococcus in all where the clinical history pointed to true gonorrhœa and the subsequent cause showed it to be such. [Two illustrative cases were cited showing the absence of the microbes in simple urethritis.]

In forty cases of gonorrhœa treated in hospital practice by Lafayette Mixture alone he had found that the time required for a cure ranged from three days to four months, the average being about two months. He thought that if by retrojections, cases could be cured within two weeks which by the other method required two months, we had made a great advance.

DR. R. W. TAYLOR.—The lateness of the hour will prevent extended remarks by me. What I should say would be in the vein of what Dr. Morrow has said. It was my hope to elicit the views and experience of the gentlemen who had been most prominent in using this new mode of treatment. I am a willing listener, and regard the matter as yet *sub judice*. As far back as 1870 I used retroinjections of mild astringent solutions with a tube constructed after the manner of Durham of Guy's Hospital in my class at the New York Dispensary, and obtained varying results. I have used in private practice and at Charity Hospital the method of Dr. Curtis, and was not greatly impressed in its favor. In my judgment the gonococcus as a definite etiological factor in gonorrhœa is as yet not firmly established by facts, observations or experiments. Time will tell.

DR. BREWER.—Mr. President, it is extremely gratifying to me that my paper has been so freely discussed. I am glad to hear the objections. Many of the points brought out in the discussion did not receive extended consideration in the paper for want of space.

Regarding the results of treatment, they were best in recent cases. With regard to stopping the discharge in one day in a specific case of gonorrhœa, I think there can be no doubt of it. I believe I have seen two cases in which a purulent discharge was stopped absolutely in one day. The watery secretion may remain for some time. In many of the cases seen within thirty-six hours the discharge stopped within two days.

A good many theoretical objections may be raised against this method of treatment, one being that the gonococci are not reached. That the gonococci do penetrate the tissues I think there is no question; but their destruction by the injections may be explained in the manner mentioned by Dr. Halsted.

Much has been said with regard to complications following the retrojection of hot water. I had heard of them before trying the method, and feared they might arise, but after considerable experience, narrated in the paper, I have not seen a complication in a single case. I do not say complications may not occur, for they are liable to occur in any case of urethritis.

I disagree with the gentlemen who claim that no advance has been made over the ordinary methods of treatment.

Isolated cases have been reported of rapid cures by other methods, but they are isolated. Moreover, it is more than probable that such cases were of a non-specific kind. Dr. Otis has taught for years that a urethral discharge which gets well inside of four weeks is not true gonorrhœa. Bumstead and Taylor place the duration of the disease at from four to six weeks—Van Buren and Keyes, from three to six weeks. But I have reported more than forty cases treated by this method of irrigation, the average duration of which was less than two weeks. The results in hospital cases are much inferior to those obtained in private practice. Hospital patients cannot be relied upon for carrying out the treatment. While the average duration of my treatment was about seventeen days, this period can be much shortened among intelligent patients. Some one has suggested that solutions of bichloride of mercury weaker than 1 to 500 cannot be antiseptic. But Koch's experiments have shown that solutions up to 1 to 10,000 are certainly antiseptic, and solutions as dilute as 1 to 100,000 completely arrest the development of organisms. Solutions of 1 to 60,000 cannot, therefore, be inert.

Dr. Brewer was not surprised at the skepticism among the profession regarding the relation of the gonococcus to gonorrhœa. The same was true in the case of tuberculosis. In each instance the experiments employed to demonstrate this relationship have been the same.

Referring to the remarks of DR. STURGIS, he said he thought that the experiments of Bockhart were fully in accord with those of Neisser and Bumm.

Reviews.

DAS VENERISCHE GESCHWÜR: Vorlesungen Über Dessen Pathologie und Therapie von Dr. Edward Lang, K.K.O.O., Professor und Vorstand der Klinik für Hautkrankheiten und Syphilis an der Universität Innsbruck. Mit Holzschnitten. Wiesbaden: Verlag von J. F. Bergmann. 1887.

IN a previous number of this JOURNAL we took occasion to comment most favorably upon Professor Lang's lectures upon the pathology and therapy of syphilis. The present volume, devoted to the pathology and therapy of the venereal ulcer, is a continuation of the same work, which will be completed by a final volume upon "Venereal Catarrh," which is announced to appear in the course of the present year.

In the volume before us the same qualities of clearness, completeness and rare descriptive faculty which characterized his former work are shown in his exposition of the nature, characteristics, clinical history and complications of the chancre, with its diagnosis and treatment.

The differential diagnosis of chancre from erosions, herpes genitalium, folliculitis, scabies, excoriations and fissures, the exulcerated initial lesion, eroded and exulcerated syphilitic macules and papules, gummatous ulcers, carcinoma, tubercular ulcers, *ulcus phagedenicum corrodens*, etc., is of especial merit, and want of space alone forbids its textual reproduction here.

The treatment of chancre and its complications is fully detailed and embodies the latest and most approved methods and agents.

DRUG ERUPTIONS: A Clinical Study of the Irritant Effects of Drugs Upon the Skin. By Prof. P. A. Morrow, A.M., M.D. New York: William Wood & Co. 1887. Pp. 199.

TWENTY years ago the idea that drugs taken internally could produce eruptive lesions on the skin would have been scouted by ninety-nine out of every hundred practitioners. The chief awakening on this subject was coincident with the practice of giving immense doses of bromide of potassium to patients afflicted with epilepsy. The very constant sequence of this practice was the appearance of anomalous eruptions of various forms, and the observant practitioner could not long remain in doubt as to their exciting cause. It was also observed that the use of iodide of potassium was sometimes followed by eruptions, differing in character from those that ordinarily accompany the disease for which this drug is so frequently given. The introduction of chloral as a hypnotic afforded opportunities for the observation of equally striking though less serious lesions, and so one drug after another was, on close study, found capable of producing with occasionally or frequently some form or other of cutaneous trouble. It was not, however, until ten years ago that serious study was given to this subject, leading during this time to reports of many striking observations, and to several monographs bearing on the subject.

The one before us is the latest and unquestionably the best that has appeared. It deals with the subject systematically, first giving its history and devoting a lengthy and valuable chapter to the general pathogenesis of these artificial eruptions. A short and unsatisfactory chapter is given to a most important branch of the subject, namely diagnosis, and this is followed by some brief remarks concerning prophylaxis and treatment. The bulk of the work is taken up with a thorough analytical study of eruptions produced by the various drugs in alphabetical order. Of these no less than seventy-five are mentioned, many of them being remedial agents in constant use, as cinchona, opium, chloral, and the various preparations of iodine and bromine. Many of the others, however, are less frequently prescribed and their incidental effects less frequently observed.

The author has evidently exercised great care in the selection of his material, doubtful observations being excluded.

This work, compiled partly from the author's own experience and partly from the recorded observations of others, will be useful to the dermatologist for reference, and is a necessity to the general practitioner, who not unfrequently brings to the former for treatment a patient suffering from an eruption which he has himself ignorantly produced by remedies given for some other disease.

H. G. P.

Selections.

CONTRIBUTION TO THE STUDY OF DIAGNOSIS IN VENEREAL CHANCRES.

DR. PAUL THIÉRY has made a study of venereal sores in the Midi Hospital in Paris, and published his observations in *Le Progrès Médical*, December 18, 1886, and January 1, 1887. He says that of all the signs which have been given as characteristic of the one or the other form of chancre, no one

is in reality pathognomonie. The signs have a real value only in their co-existence, and this is what he attempts to show in examining them one by one. These signs he considers under the headings:

Uncertain.—Frequency, site, number.

Probable.—Early development of the lesion aspect of the chancre, form, purulent secretion, characters of the adenopathy.

Certain.—Previous syphilis, induration, inoculation.

1. *Frequency* gives little aid in diagnosis. The best authorities are not agreed upon the relative frequency with which hard and soft chancres occur. Fournier gives 215 simple chancres out of 341 cases observed. While Cullerier gives 250 hard chancres, 143 soft, and 21 doubtful, out of 414 cases observed at the Midi Hospital. The author's observations agree with the latter result.

2. *Situation* has a value only in special cases. Cephalic chancre is always syphilitic (unless produced by experimental inoculation). Upon the genitals, chancre at the frenum is often of the soft variety; that of the meatus and neighboring portion of the canal, indurated.

3. *Number*.—Syphilitic contact can produce inoculation at several points before general infection is manifest. Fournier found, out of 456 patients examined, 241 who presented a single sore, and 115 who had multiple syphilitic chancres, and he cites an exceptional case of a patient found with nineteen syphilitic chancres. The author found in fifteen cases of syphilis taken at hazard, nine with single sores, three having two each, two showing three, and one presenting seven well-marked primary sores.

The probable signs are all objective, save the first.

1. *The time passed between the first appearance of the lesion and the suspected Coitus*.—This furnishes an excellent sign when the history is trustworthy. The infecting chancre rarely appears before the fifteenth day, and ordinarily from the twenty-fifth to the thirtieth, but at times much later. The soft chancre, on the contrary, appears from the second to the sixth, and very rarely (one could almost say never) after the tenth day.

2. *Appearance of chancre*.—The syphilitic chancre does not suppurate, while the soft chancre gives rise to an abundant flow of pus. The infecting chancre has a dark red color, and a varnished-over appearance which is peculiar to it. These signs are not constant, for the subpreputial syphilitic chancre may provoke a balanoposthitis and an abundant secretion. The simple chancre, freed from the pus which it secretes, and pressed between the fingers, exudes a lymphoid and at times sanguinolent fluid, which, however, is less abundant than in the syphilitic variety; but the variety of true chancre called pultaceous could easily lead into error.

3. *Aspect of the borders and form of chancre*.—Symmetry is the characteristic of the infecting chancre; the borders are usually regular and the form circular. The two halves match exactly when the sore occurs in the balanopreputial furrow. This at times elevated above the surface, but in other cases slightly excavated. The borders are never undermined, irregular or ragged, and having a red edge, as is the case in simple chancre.

Here certainly are signs which are clearly defined. The undermined condition of the borders, the worm-eaten appearance of the base, and the red border, are valuable elements in diagnosis, but how often are these characteristics doubtful, how many chancres present hybrid characters or signs of the two diseases so associated as to make diagnosis difficult.

4. *Adenopathy* in syphilis is usually bilateral, multiple, non-inflammatory, not painful but indurated, and there is no tendency to suppuration. In simple chancre there is either no adenopathy, or it is monoganglionic ordinarily superficial, with marked tendency to suppuration, or at least there are inflammatory and painful phenomena.

According to the author's observations, syphilitic bubo suppurates in from 1 per cent. to 2 per cent. of cases, but is due to the entrance of septic agents through the sore which here acts as a simple wound.

As regards *certain signs*, there is one which to-day is undoubted. Syphilitic chancre does not recur, at least not during the first years which follow the primary infection. Every chancre, then, which appears in a syphilitic is a simple chancre. Previous syphilis is, however, often very difficult to establish.

Induration is either absent in simple chancre or exists as inflammatory induration of the base of the sore. Certain syphilitic chancres, however, have no induration. In four cases the author observed there was absolutely no induration, although a roseola proved that infection had taken place. Small, soft chancres of the sulcus may at a certain period of their evolution become surrounded by a sort of indurated cushion.

Inoculation is, without doubt, the proof par excellence of the nature of the chancre, either when it occurs from contact with an opposing surface, as upon the contiguous surfaces of the prepuce, or the internal surface of the thigh opposite the sore on the penis; or when it is produced by the physician as a means of diagnosis.

After this rapid examination and somewhat superficial view of the characters of venereal ulcers, the author formulates the following proposition: "The chancre has no characteristics which are truly pathognomonic (excepting inoculation) and the diagnosis rests upon the occurrence of a certain number of signs which have no absolute value excepting by their coexistence."

During the past year two authors, Balzer, of Paris, and Leloir, of Lille, have published their researches undertaken with a view of clearing up the uncertainty surrounding this subject.

Their method is founded on the observation that syphilitic chancre, purely erosive, extends upon the surface without destroying the tissues, while the corrosive *chancrelle*, as they term the lesion, extends deep down into the tissues of the skin, destroying its elastic network; and it is precisely upon the discovery of elastic fibres in the products of secretion of the chancre that their method rests.

When the signs of chancre are obscure, and inoculation is impossible, Balzer says, substantially (*Société de biologie*, March 20, 1886): "We study the products of secretion of the different ulcerations which the case resembles, to arrive at a diagnosis. If pus alone is found, it is a case of herpes; if there is pus and epithelial cells, we have to do with a syphilitic chancre; if elastic fibres exist in addition, the lesion is a soft chancre. This procedure has succeeded in the fourteen cases in which I have employed it."

The method of examination consists in *gently* scraping the surface of the lesion with a blunt instrument, and spreading out evenly upon a glass slide the secretions removed, just as in bacteriological examinations. The preparation may be then rapidly passed through the flame of an alcohol lamp. It is then placed for two or three minutes in a saturated alcoholic solution of rosin. It is then dipped into a 40 per cent. solution of caustic potash for half a minute or a minute, and washed with distilled water, allowed to dry, and

mounted in glycerine. A microscope giving three or four hundred diameters is sufficient for the examination. The elastic fibres are found tangled up, resembling a bunch of vernicelli.

The author concludes:

1. If elastic fibres are found in the preparation, the lesion may be either a simple or a syphilitic chancre, but never a herpes. A positive result should favor the diagnosis of simple chancre.

2. If no elastic fibres are found, the examination should be repeated to remove all sources of error. If they still are absent, the lesion may be one of herpes, or it may be a syphilitic chancre (proving the histological examination exact); or it may be a simple chancre (an histological error being present). Cases are relatively rare in which simple chancre does not show elastic fibres.

Certainty is not greater by this method than negative inoculation offers, but it has the advantage of saving the patient the pain and repugnance of auto-inoculation.

No sign as yet is absolutely and constantly demonstrative, and oftentimes we must await the roseola to pronounce positively the nature of a given lesion.

Items.

IODOFORM IN THE TREATMENT OF LUPUS ERYTHEMATOSUS.

—In certain forms of lupus, as for example erythematous lupus, or lupus of the mucous membranes, iodoform, internally administered, may give good results. Besnier (*Journal de Médecine*, Bruxelles, January 5, 1887) at times prescribes the following: Iodoform and medicinal soap, each 10 centigrams to be taken twice daily in pill form.

If the iodoform is well tolerated, the dose may be increased up to a gram of the substance a day. Certain ill effects may be observed from this dose, such as tendency to sleep, coryza, etc. Nevertheless, iodoform is well supported by the stomach. The patients give forth a light iodoform odor. It is a mode of treatment which may be tried before resorting to more active measures.

GUMMY SYPHILIDES.—Besnier says (*Journal de Médecine*, Paris, February, 1887): “Gummy syphilides of the lower extremities extend very rapidly in persons who do not pay due regard to personal cleanliness and care of their person. By instituting proper reforms in this direction we can greatly modify the appearance of these lesions. In such cases, independent of internal treatment, we should prescribe poultices moistened with Van Swieten’s fluid, followed by a dressing such as the following:

R. Ung. de Vigo

Styrax.....ãã 10 grams

Vaselin..... 50 grams

together with foot baths containing a decoction of walnut leaves. In a few days the lesions will be found greatly improved.

AMERICAN DERMATOLOGICAL ASSOCIATION.

At the last annual meeting it was voted that the officers of this Association issue a call to foreign dermatologists of note to be present at its next

annual meeting, and to present papers at that time. In accordance with this resolution, the following invitation has been extended to a number of foreign dermatologists:

SIR—You are hereby cordially invited by the American Dermatological Association to attend its next annual meeting, which will be held at Baltimore, U. S. A., on Wednesday, Thursday, and Friday, August 31, and September 1 and 2, 1887.

The Association ventures to express the hope that you will honor it by your presence on that occasion, and also that you will present a paper or communication upon some subject connected with dermatology. The titles of all papers and communications should be sent to the Secretary before July 1, 1887.

H. G. PIFFARD, M.D., *President*.

G. H. TILDEN, M.D., *Secretary*.

ASSOCIATION OF GENITO-URINARY SURGEONS.

THE first Annual meeting of this Association will be held at Lakewood, New Jersey, May 17 and 18, 1887.

The Programme of Exercises embraces the following papers:

1. Address of Welcome. By the Chairman, Dr. E. L. Keyes, of New York.
2. Connection between Masturbation and Stricture of the Urethra. By Dr. S. W. Gross, Philadelphia.
3. On Chaneroid. By Dr. F. B. Greenough, Boston.
4. On Horny Growth of the Penis, with Exhibition of a Remarkable case. By Dr. J. H. Brinton, of Philadelphia.
5. Supra-pubic Cystotomy for Vesical Tumor and Large Calculus, with Comments upon Suture and Suggestions for Drainage. By Dr. E. L. Keyes, New York.
6. Case of Hysterectomy for the Relief of Pyelitis from Obstruction. By Dr. A. T. Cabot, Boston.
7. On the Choice of Operation for the Removal of Vesical Calculus in Cases Complicated by Prostatic Obstruction. By J. P. Bryson, St. Louis.
8. Idiosyncrasy as Affecting the Specific Treatment of Syphilis. Dr. P. A. Morrow, New York.
9. Observations on the Use of Oil of Winter-green in the Treatment of Gonorrhoeal Rheumatism. Dr. R. W. Taylor, New York.
10. Some Cases of Pyelitis in which Frequent and Painful Micturition was the Chief Symptom. Dr. G. Chismore, San Francisco.
11. On Temporary Overstrain of the Bladder, Producing Chronic Retention of Urine. Dr. F. N. Otis, New York.
12. Early Syphilitic Epididymitis. Dr. J. N. Hyde, Chicago.
13. Prostatomy for Obstruction; Two Cases. Dr. A. T. Cabot, Boston.
14. Plea for the More General Use of Nitrate of Silver in the Deep Urethra, with an Improved Instrument for its Application. Dr. E. L. Keyes, New York.
15. Rare Form of Septicæmia following Operation for Urethral Stricture; *Septicæmie Eroudroyante Gazeuse*. Dr. R. W. Taylor, New York.
16. Exhibition of Sections of Tubercular Testes, with Bacillus, and of Co-existent Bacilli in the Sputum. Dr. R. W. Taylor, New York.

EDWARD L. KEYES, M.D., *Chairman*.

R. W. TAYLOR, M.D., *Secretary*.

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JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

VOL. V.

JUNE, 1887.

No. 6.

Original Communications.

ON PRURIGO.

BY

TOM ROBINSON, M.D.,

Physician to St. John's Hospital, London, and Lecturer on Diseases of the Skin.

I CANNOT help thinking that every intelligent member of our profession must at times have been sorely puzzled as to what significance he could attach to the substantive word prurigo.

I find on a search into the literature of the subject that the word has been applied to the most variable conditions of the cutaneous surface. At one period we find almost any skin disease which itched was designated prurigo. Later on (I allude to the time of Willan and Bateman), when a new era in dermatology commenced, we find all the varieties of lichen figuring in their atlas of skin diseases as prurigo with a fanciful adjective stuck on; thus we find in their atlas, plate VI.:

Fig. I., prurigo mitis.

Fig. II. and III., prurigo formicans and prurigo senilis.

Fig. IV., representing an insect which was found in the skin of an old man affected with prurigo senilis, which is probably a hair in its follicle.

Again, it would appear that even Hebra selected a number of scratched skins, scratched to an intense degree of thickening,

and sketched them with his masterly hand, designating these cases and these alone, prurigo.

It was this graphic description which brought into the field Mr. Hutchinson, who has written a most suggestive and interesting article on Hebra's prurigo in his work on clinical surgery.

On tracing my own ideas of prurigo, which I carried away from student days, I am obliged to confess the image which I then had of the disease has slowly but surely become obscured, then obliterated, until I find myself doubting the very existence of a malady which I was once examined in, and doubtless described with more or less minuteness, and which is still asserted by many to be a clinical entity as much as cholera, or psoriasis.

It will be best, I think, to relate with some detail three cases of skin disease, each differing in most important details, each having its own phenomena, history and termination, and each fitting into descriptions of prurigo as delineated by dermatologists.

The history of my first case is written by my patient, a most intelligent Austrian, and I will give you his own words :

I. T., aged 38. "I was born at Trieste. The first symptoms of irritation were apparent on the calf of my right leg in the year 1875, but as they were but slight and passed away again quickly by change of air, little notice was taken of them. The next sign took place in the spring of 1876, on the back of both hands, which, however, was also easily disposed of by the application of carbolic acid and glycerine. The following year, 1877, I was vaccinated, and about three months afterwards (I should say about April) I had the first serious signs of an eruption on my face and ears, and it was at this time that I first became aware of the name of my complaint, namely, eczema, a word which, up to that time, I had never heard. In the latter part of the same year, my legs and feet were attacked, and gradually it spread to other parts of my body. While this disease was in progress I had another ailment to contend with, viz., abscesses in various parts of my body, on my eyelids, thighs and buttocks, etc. The nails were also attacked, and in a most peculiar manner: first came a burning sensation round the base of the nail, accompanied with an eruption of a yellow, thin fluid. Shortly afterwards the nail in growing up, showed on the spot where the burning was most intense, one or more small holes. The nails grew up, but have never since been of the same shape or color as before.

"At the commencement of the attack the skin wept, but about two years afterwards the whole surface began to sweat, and this sweating is at times so severe that I am obliged to change my linen two and three times a day, and also at night. My hands

and feet are very painful with large cracks, which heal up at times very quickly, and as quickly reappear again without any apparent cause.

"I have gradually lost my hair on the surface of the body, and partially on my face and scalp. I may also add that when I have had a severe fit of sweating I am very cold. Sleep at night is more the exception than the rule, and, though I eat heartily, I lose flesh. My father and mother died of cholera when I was an infant. I am without brothers or sisters. When a child I suffered much from eruptions on my face, and the skin on the backs of my hands has always been very coarse."

I have several notes about this most interesting case, but I will not trouble the society with more than the last, which was made on May 14th of this year. It is as follows :

He complains of a continual sweating and irritation of the skin ; especially is it irritable when his skin is dry. He is losing flesh. His urine is creamy (it was alkaline and loaded with amorphous phosphates). The skin is decidedly better now than it was in the winter, but he is worse when the weather is extreme. After he has been sweating he feels chilly. He has a slight cough.

On taking off his garments his shirt was distinctly wet with sweat, although he had changed it twice during the day.

His skin is of a salmon red color, and there is a smell of decomposing matter, like a horse hoof, about him.

He can roll up masses of epidermis like one sees in such situations as the sole of the foot or between the toes.

He has under his skin, especially where he says it itches the most, *i. e.*, between his shoulders and on the front of the sternum, masses about the size of peas, only flattened, which are moveable and white. The limbs are hairless.

He has great enlargement of the parotid, cervical, axillary, intercostal, and inguinal glands. These glands are dense, painless, and look like potatoes under the skin. The natural depressions and elevations of the skin are much exaggerated. This condition is most intensified on his hands, knees and elbows.

The nails are black, lustreless and deeply furrowed.

He has deep rhagades of his hands.

He has ectropion of his lower eyelids.

His skin is not in the least scaly, neither does it weep like eczema.

When he stands in my room he keeps shivering and scratching himself.

Can we doubt this is a case of eczema ?

Let me pass on to another case.

W. R. G., æt. 45, is without any known inherited tendency to skin disease. He is subject to attacks of spasmodic asthma.

Three years ago he had skin disease on the flexors of elbows and knees. This was cured, but returned eight months ago.

Inspection.—His trunk is free from any diseased condition; on both his arms, but only on the outer side, he has a mixed rash, composed of scratched papulæ, lichen spots, hypertrophied skin structures, and pigment. The hypertrophy is most marked at the bend of the elbow.

A similar but much exaggerated condition affects both his legs.

There are very few hairs on the posterior, anterior, or external surfaces of legs, and in these positions the hairs can be seen in some instances broken off short, in others, just peeping from their follicles, whilst other follicles are closed.

He has a good crop of hair on his sternum, pubis, and axilla, also on his scalp and face, and where the hair grows he has neither itching nor eruption. He has slight adenitis of his inguinal glands.

I take these two cases as illustrating the group which Hebra described as prurigo. The first one, who is curiously an Austrian, fits exactly into his description. The malady seems to have grown up with him, has gone on increasing in severity, is worse in cold weather when his skin is not pleasantly moist, has produced enlargement of the lymphatic glands, and looks as if it would go with him to his grave.

My second case comes lower down in the scale, but it is in the same group.

These cases must be very common in the practice of any dermatologist and are probably designated eczematous—a classification which I should in no way question, as a matter of fact. I should simply classify them as cases of eczema occurring in patients with pruriginous skins, which skins had been scratched into the intense and incurable condition of the patient whose case I related first. I have now seen three instances of this condition. The history was in each instance similar—a history of an irritable and harsh skin spreading over the patient's life, a skin which was influenced by many irritants such as flannel, cold winds, sun, dust, dirt, etc. But when the elephantoid condition, the enlarged glands, the phosphatic urine and the loss of flesh took place, the patients were hopelessly and irremediably ill. I will now relate briefly the history and symptoms of a case of pruriginous skin in a patient with obstructed hair follicles:

J. B. is 42 years of age. He complains of itching and dryness of the skin; which has existed since he was twenty years of age. The itching is worse in the winter than in the summer, and is increased by the heat of the fire.

Inspection.—He is a well-built man, whose occupation consists in playing eight instruments at the same time. The outer aspects of his limbs feel dry and shotty. This applies especially to his legs and on the prominent positions, such as the buttocks; the outer and front aspects of his legs, over the inner condyles of the femur, he is without surface hairs; but where the hairs should be papulae are situated, which papulae have a dark centre, can easily be dug out with a penknife; and in many of these can be found a hair, sometimes curled up like a watch-spring, but practically a hair which is imprisoned in its own cell. There are a few blood crusts where he has scratched himself, but there is not the slightest weeping or scaliness of skin. He says he often digs a little reed-like body out of the skin.

I believe if we strip all our cases of what Mr. Hutchinson and Professor Dühring call winter prurigo we shall find these obstructed hair follicles in them all. It will be remembered that some discussion took place as regards priority of discovery respecting this condition, but it was described by Dr. Handsent, of Munich, in 1845, as *pruritus hiemalis*, and you will find that the late Mr. Startin and others have drawn attention to the association of itching and obstruction of hair follicles. No doubt the muscles of the skin, which are inserted with the hair on the surface where they slant, are irritated by the cold weather, and being irritated they become active. This activity would raise the hair in such a manner that it would irritate the hair-sac. We see the best example of reaction of these muscles in the horse on a cold day. Their coats are said to stare, or, as we should express it, the arrector-pili muscles are stimulated by the cold and raise the hairs perpendicular to the plane of the horse's skin. It is by reaction of these muscles that the horse and other animals jerk off flies or other obnoxious bodies.

As a digression bearing on this I may call attention to the great irritation which is associated with the development of the acne of puberty; in many cases it is the symptom which brings our patients before us. We are frequently consulted for irritation in one spot. I have in my mind a patient I saw the morning I wrote this paragraph. He came to see me for an itching in one spot, which was worse when he had finished his day's work. On stripping him I found a spot not larger

than a half crown over the spine of the right scapula which spot was clearly defined and without a single hair growing upon its surface. The epidermis was distinctly thickened. I have another instance attending me here as an out patient who has over the head of his right tibia an oblong patch of raised, colorless and hairless structure, which gives him a great deal of trouble. This patch has existed for over thirty years. Both my patients have a good crop of hair elsewhere.

I will now take another group of cases, those which Mr. Hutchinson, Sir Erasmus Wilson and others have written upon and which have received such names as Varicella prurigo, lichen urticatus and lichen prurigo, cases which occur in early life, and which get well as puberty approaches, and which form such a large proportion of the young children which are brought to a skin hospital. The condition comes on from the first to the fourth year, as a rule, and consists of scratched lichen spots, which spots in some instances become urticarious. The eruption always appears on the outer aspect of the limbs, across the loins, and the lower part of the belly. It is not always easy to define the exact character of the eruption; sometimes it is a solid colorless papula; if this is scratched it becomes red, often vesicular, and where an eczematous diathesis exists eczema follows, with enlargement of the lymphatic glands. The itching is worse in the spring, but it never entirely disappears until the puberty hairs grow. The eruption varies much, even from day to day. As it dies out it goes away like a bruise. It has been suggested that where the wheals appear on the soles or the palms it is a proof that the pruriginous condition was set up by a blood disease, such as measles, or chicken-pox, hence the name varicella-prurigo. Whilst in those cases where these situations escape, the condition is said to have its origin in an external irritant such as fleas or bugs, my own experience would prove that this distinction is not clinically accurate, as in some of my cases I have not been able to discover that the rash was in any way a sequence of an exanthem, although there have been distinct wheals of soles and palms, together with the scratched lichen elsewhere. Rather should I believe that this form of prurigo is a lichen occurring in a pruriginous skin, and I assert this the more confidently because the natural history of these cases show that when a copious crop of hair is produced on the trunk at the age of puberty the activity of the hair follicles come to an end and the condition ceases.

(To be continued.)

A BRIEF CONSIDERATION OF INFLAMMATORY STRICTURE OF THE MALE URETHRA.¹

BY

JOHN BLAKE WHITE, M.D.,

Visiting Physician to Charity Hospital, Consulting Surgeon House of Refuge, L. I., Fellow of the Academy of Medicine, etc.

THE spasmodic and organic or permanent strictures are the only two forms of urethral stricture described by Sir B. Brodie, while Sir Astley Cooper, in his classification, included an inflammatory or congestive variety as not infrequently met with. Such authorities as Acton, Erichsen, Sir Henry Thompson, Otis and others also recognize this form of stricture. Dr. Otis accepts the existence of congestive stricture, but positively declares that it is never present as an independent affection, but is always associated with one of the other types of stricture. My own experience tends to corroborate his views in this regard, for I cannot recall an instance of this affection occurring that a spasmodic or a permanent stricture of either large or small calibre could not be found as a complication, when a careful and intelligent examination of the urethra was instituted. By inflammatory stricture, a condition of congestion of the urethra is referred to, which occasions so much narrowing of the canal as to interfere with the act of urination. Complete retention of urine may result, or the flow may be rendered difficult and painful.

The peculiar construction of the urethra throughout renders it especially susceptible to inflammatory conditions. It consists, along its entire length, of a vascular membrane exposed to a variety of irritating causes, and that inflammation does not more frequently occur is a matter of remark. This form of stricture is without doubt the most commonly observed, for it is invariably present to a greater or less degree in every other class, and whenever it is met with I would be disposed to look upon it as symptomatic of spasm or the existence of more permanent lesions rather than as an independent affection.

Organic stricture may frequently be overlooked until attention is called to the condition of the urethra by an acute congestion at one or more points, and the latter condition, unless properly managed, might result in the establishment of a troublesome permanent lesion. Certain portions of the urethra are more prone to congestion than others, namely, the membranous, prostatic, and that part which includes the fossa navi-

¹ Read before the Lennox Medical and Surgical Society, April 11, 1887.

cularis. Any other part of the canal may, however, be subject to inflammation, or the urethra throughout its entire length may be affected. Among the prominent causes of urethral inflammation gonorrhœa, probably, ranks the first in importance; then follow undue sexual indulgence, the irritating effect of urine, too concentrated or highly acid, masturbation and renal calculi. The introduction of instruments for purposes of diagnosis constitutes a frequent cause of inflammatory stricture, especially if too hastily or roughly performed. Sir Astley Cooper states that he has most frequently observed inflammation of the urethra produced by passing instruments in cases where spasmodic stricture existed, and he thinks the presence of spasm a very frequent complication of the former condition.

Persons of a gouty or rheumatic diathesis with especial liability to cutaneous and mucous affections are sufferers, by preference, from this class of strictures. In such subjects, therefore, all forms of urethral instrumentation should be withheld as far as practicable and only resorted to with the greatest care and skill when positively required. I have seen the introduction of a small-sized catheter for the relief of retention of urine excite a painful and troublesome urethritis, and yet I have been impressed with the remarkable degree of tolerance which the urethra will sometimes manifest to surgical interference under apparently very adverse circumstances. The presence of hemorrhoids, fistulæ in ano and other morbid conditions of the rectum should not be overlooked as potent exciters of urethral inflammation by reflex influences.

A frequent cause of this form, as well as of any one of the other varieties of stricture, either as an independent affection or associated with congestion of the urethra, is the use of medicated bougies for the so-called cure of gonorrhœa. This method of treatment of urethritis frequently results in troublesome forms of inflammatory stricture and also some of the most obstinate forms of permanent stricture met with in practice. Medicated bougies cannot be too strongly condemned in the treatment of gonorrhœa or gleet, especially such as are sufficiently charged with astringents to produce any appreciable effect. Acton¹ refers to caustic bougies as causes of retention of urine resulting from urethral inflammation, and I believe few, if any, authors entertain opinions in favor of adopting such remedial means. Drui²tt very properly attributes inflammation to abuse of in-

¹ Urinary and Generative Organs.

² Drui²tt: Modern Surgery.

jections or to exposure and interference during the acute stage of gonorrhœa. Erichsen¹ considers that chronic and long continued inflammation of the urethra occasions congestive stricture by the swollen condition of the mucous membrane which is transitory. The same author emphasizes lithiasis as a direct cause of inflammatory stricture. I have not observed any allusion by authorities to forced or voluntary retention of urine as a very probable factor in the causation of the form of stricture under consideration, although some cases of acute inflammation can be undoubtedly traced to this cause.

Symptoms.—The first symptom which often attracts the patient's attention is a slight stinging along the urethral mucous membrane, especially during the act of urination. This condition may not necessarily follow recent coitus, as in gonorrhœa. The burning or scalding on urination gradually increases in severity and is often associated with painful and uncontrollable desire to pass water. This sensitive state of the urethra oftentimes does not cease after the bladder is emptied, as is the case in gonorrhœa, or in other forms of uncomplicated urethral stricture, but the symptom continues, as patients describe it, "*like a hot coal*," extending throughout the entire length of the urethra, though manifesting its intensity at the meatus.

Naturally the patient shrinks from urinating while the irresistible inclination to do so remains. Other symptoms occasioned by an impediment, to the free flow of urine are soon manifested, such as suprapubic pain, vesical tenesmus, the passing of urine after repeated efforts either in a very diminutive stream or guttatum. The penis presents an inflamed appearance and the lips of the meatus appear red, swollen and everted. A sense of weight and fullness of the perineum is often associated with painful defecation, especially when the bowels are constipated. Sometimes complete retention of urine is observed, and the condition might naturally excite a suspicion of the presence of an organic stricture. A slight urethral discharge occasionally makes its appearance, but this is usually an indication of a subsidence of the acute stage of inflammation and should be generally regarded as a favorable symptom. This condition, being very closely allied to the several forms of urethritis, sometimes constitutes a particularly troublesome affection to overcome, therefore great judgment and skill must be exercised in its treatment in order to avoid relapses. The slightest errors of diet must be avoided and local irritations from any cause, so far as

¹ The Science and Art of Surgery.

practicable, alleviated or removed. The condition of the digestive organs requires particular attention, especially as regards the regulation and restriction of diet and the administration of such appropriate remedies as are calculated to restore tone to their respective functions.

The general system sympathizes to a greater or less degree as indicated by fever, rapid pulse, and more or less nervous irritability, which symptoms are not prominently present in other classes of stricture when uncomplicated with inflammation, and may safely be considered symptomatic. When much febrile reaction is present it is preceded by severe headache, backache, general languor, lassitude, and chilliness which assumes, in some cases, the gravity of rigor, and indicates the degree of inflammation present as well as the proportionate severity of the associated symptoms.

The first evidence of urethral inflammation will sometimes manifest itself by an acute retention of urine, though this is most commonly a symptom of spasmodic stricture.

The treatment of congestive stricture is not by any means a simple matter, but on the contrary will seldom fail to test the judgment and skill of the medical attendant.

Every practical means for the immediate alleviation of the most distressing symptoms should be promptly carried out without expecting to include in the plan of treatment remedial measures which may abort the affection.

That which generally causes the greatest amount of disturbance is the intense inflammation associated sometimes with retention of urine. If these two conditions can be overcome within a reasonable time, many of the other symptoms which prove more or less a source of suffering will also be ameliorated. A warm sitz bath should be ordered and the patient directed to remain in it at least fifteen minutes. When retention of urine is a prominent symptom, the patient should attempt to urinate while in the bath, which he will succeed in accomplishing in a majority of instances. This means for the relief of retention should, therefore, be always tested before any attempt is made to introduce the catheter. The importance of this, it is desirable to emphasize, because I believe that the bath sometimes fails to give relief when repeated efforts to pass the catheter have been previously made without success. The irritation thus excited tends to greatly aggravate the condition of spasm, which constitutes a complete barrier to the flow of urine or the introduction of any instrument. Sir Astley Cooper used to recommend gen-

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eral bleeding, but I have seen no case which failed to yield in time to less aggressive measures. The local abstraction of blood by one or two leeches applied to the perineum would better answer the purpose and less danger from their use would be likely to follow. At this stage, a diuretic mixture containing the acetate of potassa, sweet spirits of nitre, and the spiritus mindererus, combined with a minute dose of tartar emetic, could be advantageously prescribed. I have found a combination of benzoate and salicylate of soda and fl. ext. of belladonna, with the infusion of buchu or pareira brava, sometimes useful. Some of the natural diuretic waters, as the Buffalo Lithia, Clysmic or Underwood Spring waters, may be imbibed *ad libitum*. If the fever continues high after the above treatment, the patient should be placed in the recumbent position, kept free from all excitement, gr. xv of antipyrin administered, and the dose repeated in two or three hours if the fever persists. For the relief of pain, a rectal suppository, consisting of pulv. opii, gr. ii-iii, and ext. belladonna, gr. $\frac{1}{8}$ - $\frac{1}{6}$, or Dover's powder, gr. xv-xx, internally, may be given. The hypodermic administration of morphia and atropia combined has acted very satisfactorily in some cases, seldom failing to give prompt and permanent relief from suffering. In retention of urine from urethral inflammation no attempt should be made to pass a catheter for at least twelve hours; in the meantime, the measures already recommended should be faithfully tried. The sitz bath, as warm as can be comfortably borne, should be repeated every hour, and an attempt to urinate while in the bath should be made each time. I do not advise straining or violent efforts at urination, but merely to favor, with a natural endeavor to expel urine, the relaxation of spasm superinduced by the influence of a warm bath or warm douche directed to the hips and abdomen. Micturition under these circumstances is often accomplished without any effort and without pain. If this method proves successful, the use of the warm sitz bath is advisable whenever urination is necessary, until there is a decided subsidence of the urethral congestion and a natural condition of the urinary apparatus once more re-established. I recall many instances where patients have readily and without pain urinated in the warm baths, or by the aid of a warm douche, as described, when attempts had been previously made, without success, to introduce a very small catheter. Occasionally, it will be found necessary to catheterize a patient, under which circumstances an instrument should be selected about one-half the size determined by Dr.

Otis's proportionate relation between the penile circumference and the urethra. No remedy in such cases has proved so eminently satisfactory in facilitating the introduction of the catheter as cocaine. Ten or fifteen minims of a four per cent. solution injected into the urethra through a long urethral nozzle attached to a hypodermic syringe, and retained for ten or more minutes, will suffice to render the urethra insensitive. Dr. Otis has made and uses a silver urethral staff with several small perforations at the extremity for the escape of the cocaine solution, and is thereby enabled to inject the urethra beyond the bulbo-membranous junction if desirable. As spasm is usually present at this very point, the advantage of getting some of the cocaine solution beyond it, is apparent. For injecting the cocaine solution to any part of the penile urethra I have had made by Tiemann & Co., and have been in the habit of using, a hard rubber nozzle with a small bulbous extremity, which is perforated so as to emit the solution in spray form downwards, upwards and outwards. The cocaine solution, besides rendering the urethra insensible to the introduction of instruments, serves the additional purposes of preventing or overcoming spasm and exerting an antiphlogistic effect upon the inflamed mucous membrane of the canal. This procedure, adopted and carefully executed in the most acute stages of urethral inflammation, will seldom fail to relieve spasm or pain when present and, by exercising its antiphlogistic effect locally, the act of urination may be sometimes promoted without resorting to surgical measures for the relief of retention. The value of etherization in these cases should not be overlooked when the measures for controlling spasm already proposed prove unavailing. Purgation in the acute stage of urethral inflammation is contra-indicated, as it would tend to aggravate rather than ameliorate pain by increasing turgescence of the vessels of the pelvis. Authors have referred to the hæmorrhage which at times follows catheterization as a result of the highly congested state of the mucous membrane, which should serve to suggest great care in all cases requiring instrumental interference. If, after a patient endeavor to relieve retention by the warm bath and douche and the use of a catheter, success is not attained, it will be necessary to aspirate the bladder. The operation can be performed either through the rectum or by penetrating the bladder in the suprapubic region. When the acute stage of congestion of the urethra has been safely bridged, which can be generally accomplished by the plan of treatment already detailed, some mercurial laxa-

tive is clearly indicated, either in the form of Plummer's pill, or, better still, a combination of the resin of podophyllin, pil. hydrargyrum, extract taraxacum and extract hyoscyamus in appropriate doses. It is rarely necessary to pass sounds even after the acute symptoms have subsided, but when such instrumentation seems expedient the greatest delicacy of manipulation is required. As a general rule, the use of sounds soon after the inflammation has abated is not advisable, whatever indications may appear for such treatment; but I am convinced that much benefit can be obtained after sufficient time has elapsed for the urethra to be entirely rid of its inflamed condition. A full-sized steel sound, carefully introduced at regular intervals for two or three months, will prove advantageous in dissipating fibrinous deposits which result from acute congestion. In each instance cocaine should be used, as it lessens the probability of irritation or a return of the urethral congestion. The pressure of the sound in its slow descent along the urethra serves to excite absorption of exudative masses, resulting from inflammation; which, if allowed to remain, would in time become organized and lay the foundation for permanent strictures.

These localized exudations are no doubt the *subacute inflammatory strictures* or *callosities* which the older writers have alluded to and ascribed to a chronic inflammation of the mucous layer of the urethra, constituting the class of so-called dilatable strictures. This condition is often confounded with permanent lesions, and no doubt represent the class of strictures in which dilatation and electrolysis afford the excellent results that have been claimed for them. This *callosity* of the urethra differs from organic stricture in that the circumjacent spongy body in the latter affection partakes of inflammation and assumes a rigid and condensed quality, instead of manifesting a loose, spongy, and dilatable character. After this callous condition is permitted to remain unattended to for any length of time, the exudate becomes permanently fixed, constituting the class of strictures designated organic, and requires a plan of treatment far more positive than that of either gradual dilatation or electrolysis.

Acton declares callous conditions of the urethra to be due to spots of fungous granulations, which are sometimes observed in the vagina or conjunctiva as the result of chronic inflammation.

Such conditions have been met with in my experience and have been remedied by the regular and careful use of metal

sounds, gradually increasing the size until the full urethral capacity is attained in accordance with the proportionate relation of Professor Otis. Further treatment of such cases consist more particularly in a judicious regulation of the diet, habits of living, remedying as far as practicable any derangement of the digestive organs and the removal of all other sources of irritation. Alcoholic stimulants should be generally withheld. My usual plan of treating these subacute cases is to direct the patient to inject or irrigate the urethra with water quite warm (114° F. to 120° F.) three or four times daily, and after introducing a few minims of a four per cent. solution of cocaine carefully to pass a sound, once or twice a week, which should be gradually increased in size to the full urethral capacity, and ought to be admitted without pain, bleeding or marked sense of resistance before discontinued. After all inflammation has entirely subsided and the meatus proves to be too small to admit a full-sized instrument, it should be incised to correspond with the calibre of the canal behind it. This procedure is advised because I am fully impressed with the fact that a contracted orifice is often the cause of much hypersensitiveness of the urethra, which frequently results in inflammation and spasmodic stricture, and can alone be relieved by meatotomy (JOURNAL OF CUTANEOUS AND VENEREAL DISEASES, June, 1886). I have found the tinct. ferri sesquichloridi, in ten minim doses every ten or fifteen minutes, very serviceable in relieving spasm when associated with urethral congestion. This treatment has been highly commended by Druitt and by Dr. Otis, especially, among more recent authors.

My conclusions are—

First.—That congestive stricture is a symptomatic affection and ought never to be regarded or treated as an independent condition.

Second.—It is always associated with a spasmodic or permanent stricture, or some other urethral, vesical, or renal irritation.

Third.—If a complication of spasmodic stricture, it need not necessarily result in an organic stricture, if it receives skillful attention.

Fourth.—If a complication of organic stricture, relapses are sure to recur unless the true stricture is removed by operation.

Fifth.—A very contracted meatus urinarius is alone suffi-

cient to cause urethral inflammation by reflex irritation, and when such a condition obtains, permanent relief cannot be expected without complete division of the orifice.

941 MADISON AVENUE.

ICHTHYOL AND RESORCIN. A CLINICAL STUDY OF THEIR EFFECTS.¹

BY

GEORGE THOMAS JACKSON, M.D.,

Asst. Visiting Physician New York Skin and Cancer Hospital.

FROM time to time, now one remedy and now another, has been introduced to the notice of the medical profession, and commended enthusiastically as almost a specific for certain diseases. For a few brief months the enthusiasm seems almost contagious; the medical journals bristle with articles from Doctors A., B., and C., proclaiming the wonderful cures they have obtained by the new remedy. But wait! A few months pass; the reports about the drug grow less, and, like a sputtering candle, the great new light goes out, while the glow from the old and well-tried remedies becomes brighter than ever.

No remedy in my time has been more enthusiastically heralded than *ichthyol*. Fired by the enthusiasm of Unna as evinced in the *Ergänzungsheft* II. to the *Monatshefte f. prakt. Dermatologie*, for 1886, I began a series of practical experiments upon the ambulant patients in the service of Dr. George Henry Fox, at the New York Skin and Cancer Hospital, the results of which are given in this paper. I was predisposed in favor of the drug, and was therefore disappointed the more with the results obtained. The preparation used in nearly all the cases was the ammonio-sulphate, as manufactured by the Hamburg Ichthyol Company, and imported by Messrs. J. White & Co., of this city, who kindly furnished the hospital with a liberal supply for purposes of experiment. To them I would express my thanks for their courtesy. This preparation was used because it was the one preferred by Unna; and it must be understood to be indicated in the following report, excepting where otherwise noted. In order to test the value of the drug itself, it was ordered in vaseline or simple ointment, and unless

¹ Read before the N. Y. Dermatological Society, April 26, 1887.

otherwise indicated, such excipients are to be understood. Its use was continued in each case for about one month, or until I became convinced that it was producing no benefit, or I could no longer withstand the appeals of my patients to stop it. With these preliminary remarks, let us proceed to a study of my cases.

I used the drug in thirty cases, as follows: Rosacea, six cases; eczema, eight cases; recurrent erythema, one case; acne, nine cases; syphilis, one case; and ulcers, five cases. In some of these, other plans of treatment had been used before ichthyol was employed, and to some, ichthyol was the first application made. Eight of the cases failed to return, and these being deducted from the total number, leaves twenty-two cases to serve as a text.

1. ROSACEA.

Of these I was able to follow only three cases.

CASE 1.—Mary S—, M., æt. 39. Rosacea of one and one-half year's standing.

June 17, 1886. Ordered a 10 per cent. solution of ichthyol (pure) in water.

July 15th. Face somewhat paler. Continue treatment.

July 31st. Face much redder, and skin inflamed. Stop ichthyol.

CASE 2.—Annie R—, machine operator, æt. 36. Rosacea with acne for one year.

June 29, 1886. Ichthyol, 5 per cent, in collodion, locally, and three drops in capsule in the morning, internally.

July 10th. Doing well. Continue treatment.

September 28th. No improvement. Stop the drug and give lotio alba, which rapidly cleared the face.

CASE 3.—Lizzie R—, M., æt. 28. Rosacea with acne for six months. August 12, 1886, ichthyol soap locally, and ichthyol in capsules internally, 3 drops A. M. and P. M.

August 19th. Face smoother, but red; continue treatment.

August 26th. Face red and sore. Bowels very loose. Continue the soap, but stop the capsules.

September 2d. Face not so red, but more acne. Continue the treatment.

September 9th. Face no better. Stop ichthyol.

2. ECZEMA.

I was able to follow all eight of these cases.

CASE. 4.—Bridget H—, M., æt. 52. Eczema squamosum

of many years' standing. A very chronic and obstinate case, with a great deal of thickening of the skin.

June 16, 1886. Prescribed a 10 per cent. ointment of ichthyol.

June 22d. Doing well. Continue ointment.

June 26th. About the same. Continue the ointment and order 3 drops of the ichthyol A. M. and P. M.

June 29th. Somewhat improved. Continue treatment.

July 8th. Feet swollen, raw and very painful, so that the patient can scarcely walk. Stop ichthyol.

CASE 5.—David S—, æt. 7 mos. Eczema vesiculosum in small patches.

June 26, 1886, order 5 per cent. ichthyol ointment and 3 drops of the ichthyol internally during the day.

July 13th. Much worse. Bowels very loose. Stop ichthyol.

CASE 6.—Albert M—, æt. 2 years. Eczema papulosum of four weeks' standing.

July 1, 1886. Ichthyol externally in 3 per cent. ointment; internally 3 drops during the day.

July 6th. Somewhat better. Continue the ichthyol to the left leg and order the ointment of zinc oxide for the right.

July 10th. The left leg (ichthyol) much worse and inflamed; the right leg much better. Stop the ichthyol.

CASE 7.—Louis B—, school boy, æt. 10. Eczema papulosum for two years.

November 6, 1886. Was ordered a 5 per cent. ichthyol ointment, which was continued up to

December 11th, and, as there was no improvement, it was then stopped.

CASE 8.—Jas. R—, peddler, æt. 32. Eczema vesiculosum upon a syphilitic base.

November 27, 1886. Was given a 5 per cent ichthyol lotion in glycerine and water. This was used for one week without any improvement. Then a 3 per cent. ointment of the subiodide of bismuth was ordered, and he was well in one week.

CASE 9.—Michael R—, coal heaver, æt. 67. Eczema varicosum with ulcer.

November 27, 1886. Was ordered a 2½ per cent. ichthyol lotion in glycerine and water.

December 14th. Great improvement. Continue treatment.

December 31st. Ulcer healed; itching lessened; skin red, thinner, dry and smooth.

January 27, 1887. Doing well. Was finally cured with a 25 per cent. ointment of cade.

CASE 10.—Leonard F——, conductor, æt. 25. Eczema madidans scroti of one month's duration.

February 23, 1887. After having greatly improved his condition by the use of rubber, he was given a $2\frac{1}{2}$ per cent. ichthyol ointment in Lassar's paste, with salicylic acid.

March 19th. The ointment stopped the itching until three days ago, after his ointment had been out one week. To test whether it was the ichthyol or the Lassar's paste that did the good, I now exhibited the drug in vaseline, preserving the strength 3 per cent.

March 22d. The ointment has converted a dry eczema into a raw and very itchy one. The ichthyol was stopped.

CASE 11.—G. P. M——, clerk, æt. 40. Eczema scroti.

December 18, 1886. Ichthyol, 2 per cent. in Lassar's paste.

February 12, 1887. Has been in comfortable condition until last week, when ointment ran out.

3. RECURRENT ERYTHEMA.

CASE 12.—Henry L——, conductor, æt. 21.

July 1, 1886. Ichthyol, 5 per cent. in water, and internally, three drops t. i. d.

July 27th. Has had several fresh outbreaks. Continue the treatment.

September 11th. A few fresh outbreaks. Continue the treatment.

October 16th. As there has been no improvement, the drug is stopped.

4. ACNE.

Four of these cases did not return after first visit, so we have only six cases for our statistics.

CASE 13.—Gottlieb R——, scullion, æt. 29. Acne for nine months.

After having treated him for some time, and got his face into good condition, he had a fresh attack on July 18th.

July 20, 1886. Ichthyol soap. Internally, bromide of arsenic.

August 3d. Face looking nicely. Continue treatment.

August 14th. About the same.

August 24th. Face well.

CASE 14.—Pauline R——, cap maker, æt. 16. Acne vulgaris for one year.

July 15, 1886. Externally, 10 per cent. ichthyol ointment; internally, three drops ichthyol A. M. and P. M.

July 22d. Face worse. Continue treatment. Did not see her again.

CASE 15.—David L——, clerk, æt. 18. Acne vulgaris for three years.

December 23, 1886. Ichthyol soap, and internally, five drops A. M. and P. M.

January 18, 1887. Has continued treatment faithfully, but without any effect, so stop it.

CASE 16.—Henry N——, grocer, æt. 22. Acne for five years.

December 23, 1886. Ichthyol soap. Internally, rhubarb and soda.

January 11, 1887. Steady improvement.

CASE 17. — Jno. M——, printer, æt. 19. Acne for four weeks.

December 30, 1886. Ichthyol soap. Internally, tr. nux vom.

January 6, 1887. Face smooth. Continue treatment.

January 15, 1887. Relapse.

CASE 18.—Minnie N——, clerk, æt. 18. Acne indurata for one year.

March 22, 1887. Ichthyol, 30 per cent. in vaseline.

March 29, 1887. Has caused an artificial eczema, so stop it.

5. SYCOSIS.

CASE 19.—W. H. G——, tailor, æt. 54. Sycosis with relapses for many years.

June 29, 1886. Ichthyol, 10 per cent. in lard.

July 6, 1886. Began to grow worse on July 4th. An acute outbreak. Reduce strength of ointment to 3 per cent. and give three drops twice a day, internally.

July 10, 1886. A large number of new pustules. Stopped.

6. ULCERS.

Two of these cases did not return after first visit, so we have only three cases for study.

CASE 20.—Bridget S——, M., æt. 39. Varicose ulcer for three years.

November 30, 1886. Ichthyol, 3 per cent. in simple ointment.

January 6, 1887. Was continued up to this date. The condition being much worse, it was stopped.

CASE 21.—Carl S——, paints, æt. 45. Ulcers of some months' standing.

March 19, 1887. Ichthyol 3 per cent. in vaseline.

March 22d. More painful. Continue treatment.

CASE 22. Eliza W—, M., æt. 46. Varicose ulcer.

March 19, 1887. Ichthyol 3 per cent. in vaseline.

March 22d. Pained so that she could not stand it. Stop.

What story does the study of these cases tell us? One of almost absolutely negative results in regard to benefiting the cases. Yes; and worse; we find that the drug is irritating and aggravated many of the conditions present in the cases.

Let me summarize my results: Ichthyol, either in the form of the soap, the pure product, or the ammonia-sulphate was used in twenty-two cases of skin diseases, as follows:

DISEASE.	NUMBER OF CASES.	AV'G TIME OF USING.	INTERNALLY. EXTERNALLY.	RESULTS AND REMARKS.
Rosacea	3	5 weeks.	Both.	1 case aggravated. No effect in 2 cases.
Eczema	8	5 "	4 cases, both. 4 " ext.	4 cases aggravated. 2 " no effect. 1 case greatly benefited. 1 " temporary benefit. It will be noticed that Case 11 was greatly benefitted, but here the medicament was exhibited in Lassar's paste. Case 10 was also somewhat benefited when using a similar combination, but made worse when vaseline was substituted for the paste. Even in Case 9, which also was benefited, the oil of cade had to be resorted to to complete the cure.
Recurrent Erythema.	1	14 w'ks.	Both.	No improvement.
Acne.....	6	2½ "	2 cases, both. 4 " ext.	1 case cured, but bromide of arsenic was given by the mouth. 2 cases made worse. 1 case temporarily benefited. 1 " improved. 1 " no effect.
Sycosis.....	1	2 weeks.	Both.	Aggravated.
Ulcers.....	3	4 days.	Ext.	Aggravated.

11 cases made worse.

6 " no improvement.

1 case cured, arsenic being given at the same time.

4 cases improved, in two of which other well-known and tried remedies were used.

Well, I am sincerely sorry and greatly disappointed at the results I have obtained; because I had hoped to find a reliable remedy for the treatment of some of the most obstinate and disfiguring of skin diseases. But in the face of what I have seen my judgment must be: Ichthyol is an unreliable preparation when used alone; in some cases it is of apparent benefit when exhibited as an adjuvant; but it is not as good as many other old and well-approved remedies.

(To be continued.)

SERPIGINOUS TUBERCULAR SYPHILIDE.¹

BY

R. W. TAYLOR, M.D.,

Surgeon to Charity Hospital.

I DESIRE to present to the society this interesting case, which shows with admirable clearness all of the features of the true serpiginous tubercular syphilide.

H. L., 31, English, machinist, seemingly healthy, even robust, and of good habits, came to my clinic at the New York Hospital, March 23, 1887.

In the early part of 1882 he had a chancre which from its history I am convinced was syphilitic, and shortly after had well-marked inguinal adenopathies, particularly on the left side. He was very actively treated and knows of no further manifestations until a year and a half later, when he had ulcerations of the roof of the mouth and throat. At about this time an ulceration began on the left arm which spread slowly downwards over a large surface, synchronously healing in the centre. In two years, under a not very systematic but often vigorous treatment, this lesion was healed and has left a characteristic cicatrix. This lesion having healed in July, 1886, in the following October the present ulcer began as a small pustule. To-day I find a typical serpiginous syphilide of the shape of a parallelogram of about six inches in diameter. The lesion is a distinctly margined ring of ulceration, nearly wholly encrusted, which incloses a typical syphilitic cicatrix which at its centre is blanched, and from that shades off to a brown and at the margin brownish red. The syphilide is now six months old, and from its size it may be judged that its course has been quite rapid. Beginning as a pustule, it has pursued the course peculiar to the serpiginous syphilide. As soon as it reached a diameter of an inch healing began in the centre, and a round cicatrix was formed which was surrounded by a ring, less than half an inch broad, of ulceration. This ringed furrow is peculiar to this form of syphilide and is of various depths in different cases; in some quite shallow, in others as deep as a third of an inch. Its inner margin is composed of the enclosed and always encroaching cicatrix, which usually grows larger, *pari passu*, as the ulcerated ring extends. The outer margin is composed of a more or less exerted lip of a line or less in width due to the greater or less destruction of the skin, this process destroying for a very limited extent the subcutaneous connective tissue thereby producing the red, thickened and everted red margin already mentioned. The floor of the ulcerated ring is similar to that of rupial ulcers, and the circumference is more or less encrusted.

¹ Read before the New York Dermatological Society, April 26, 1887.

The existence of a complete ring of crusts prompted Ricord to call this lesion "syphilide annulaire."

The date of evolution in this case of this syphilide was quite early, the first lesion having begun in the eighteenth month of the disease, followed by the present one two and one half years later. This may be considered rather precocious, since in my previous study in quite a large number of collected cases the date of evolution was found to be between the fifth and fifteenth year of syphilis.

Years ago I was of the opinion that this syphilide generally appeared in markedly cachectic persons. Further experience has shown me that it may occur, as it has in this patient, in those in whom no ill health is apparent.

This syphilide may begin as a papule which falls into ulceration as a pustule, as it did in this case, in a tubercle or a gumma. Its seat of predilection is on the extremities near the larger joints. In this case its first manifestation was upon the arm, and its later one upon the abdominal wall—a less frequent site.

(Under the mixed treatment, alone, the syphilide was healed in one month.)

A worthy colleague and member of this society remarked to me, after inspecting the foregoing case, that he differed from me in the opinion that the serpiginous syphilide is rare, since he thought it was quite common. This opinion is due to the fact that many do not sharply limit the term serpiginous to syphilides such as I have just described, but apply it to ulcerating precocious syphilides, later ulcerating syphilides, gummatous and non-ulcerative syphilides which increase peripherally. I claim, however, very strongly, that such a designation is wrong and that the term serpiginous should only be used in describing lesions such as were seen in this case.

The case which I now present, which was kindly referred to me by my clinical assistant, Dr. C. W. Cutler, will show what is by many understood to be the serpiginous syphilide. The history is as follows:

G. B., 29, American, 'longshoreman, contracted syphilis eight years ago, and was treated for two or three months only. Two years later had pains in shins, rheumatism, a scaly papular rash and iritis. These were cured by treatment in three months, but the nocturnal pains recurred in a year. Eight months ago the present lesions began as a small scab on the right shoulder. Here you will see large patches of the resolute or non-ulcerative tubercular syphilide, which are growing by festooned bor-

ders, while in the centre healing is observed in the thin, depressed cicatrices. Thus it may continue without a particle of ulceration or one drop of pus, the infiltration going on at the margin and absorption occurring synchronously in the centre.

I have a colored drawing of a case of this kind in which three-quarters of the integument of the body was invaded during a period of years, and yet, though the major portion was atrophied, there had never been any ulceration. In the case before us you will see scattered ulcerated points over the spine of the scapula, but these are accidents due to pressure and motion, and are not essential parts of the morbid process. It may be urged that though non-ulcerative this syphilide is also serpiginous, which is true. But it is quite exceptional to see this spreading tendency in this syphilide, while this feature is the rule in the ulcerated variety of the first case. It must be remembered, moreover, that not infrequently the precocious and late lesions take on ulceration, lose their own characteristic features and become cases of typical serpiginous tubercular syphilide. Further facts as to this interesting syphilide may be found in my essay upon it in the *American Journal of Syphilography and Dermatology*, January, 1870.

My idea as to the nature of the morbid process is that a proliferation of granulation cells occurs at the margin of the serpiginous tubercular syphilide in the everted lip and that this is rapidly followed by the ulceration in the enclosed furrow or ring and that within this ring of ulceration healing takes place synchronously, so that the latter process keeps pace with the outlying ulceration. It is a marked illustration of more or less rapid new growth and synchronous decay.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

172D REGULAR MEETING.

DR. ROBT. W. TAYLOR, *President, in the Chair.*

THE discussion of the cases presented at the last meeting being first in order, that presented by Dr. Elliot as one of

TROPHONEUROSIS AFFECTING THE NAILS

was first taken up.

DR. FOX coincided with the view held by Dr. Elliot that the disease was solely a local trouble.

DR. ELLIOT said the case had progressed gradually and the same changes had taken place in the toes as were noticed in the fingers at the last meeting. The patient had not been put under treatment. His general health had deteriorated, the patient becoming very tired on slight exertion and the same vaso-motor changes had taken place in the toes. He considered his original diagnosis confirmed by the course the disease had taken.

The second case was that shown by Dr. BULKLEY as one of

DERMATITIS HERPETIFORMIS.

DR. ELLIOT said that he had since seen this case and that vesicles had appeared, but in other respects the eruption had not changed in appearance.

The next case was that presented by Dr. SHERWELL as

MYXEDEMA.

DR. SHERWELL said he had continued with the same mixed treatment she had been taking, not because he considered the disease syphilitic, but because he thought an alterative treatment was indicated, and she did well under its use. He had not been positive in regard to the diagnosis of myxœdema and had first considered the case one of lymphangioma, and he was not sure it might not be this disease after all, although he never had a case more nearly approaching myxœdema. Perforation of the tissues in the region of the cheeks had taken place owing, he believed, to the treatment (Ung. hydrarg. locally and mixed treatment internally). All the patient's children are healthy and the husband gave no history of syphilis.

DR. TAYLOR said he had seen precisely the same condition as presented by Dr. Sherwell's patient, with lesions of the same appearance upon the face, but in his cases there had been gummatous infiltration of the palate and nose, and the disease had been attributed to disturbance of the circulation due to neoplastic infiltration.

It is not at all uncommon to see patients with naso-pharyngeal troubles suffer from conditions which are attributed to erysipelas. In the case presented there were no doubt lymphangiomatous complications.

DR. ALLEN presented at the last meeting a case of

PERI-URETHRAL TUMOR IN A SYPHILITIC PATIENT.

Jos. W—; æt. 21. The tumor was situated just behind the fossa navicularis extending upon both sides of the median line and surrounding the urethra. It occupies the region in which peri-urethral abscess is frequently seen, but in the case presented the enlargement shows no tendency to suppurate, is entirely devoid of pain or tenderness and appears to be connected with the cicatrix of the infecting chancre, the enlarged mass and scar moving together and appearing to be continuous. If this be a case of gummy tumor it illustrates the tendency of hardness to return in the scar of primary syphilis.

The patient first came under treatment in 1884, made a good recovery from his primary and secondary lesions. On November 29, 1885, he again presented himself with a tubercular syphilide of a serpiginous variety upon the prepuce and serotum, mucous patches, headache and other manifestations of the disease. He now remained under treatment until April 11, 1886, although he was soon free from all signs of the disease. Now just one year later he returns with the condition above described, and shows a slight amount of adenopathy but no other pronounced symptoms of disease.

The tumor appeared three weeks ago and has gradually increased in size. He has been under anti-syphilitic treatment one week.

Patient had gonorrhœa about six months ago.

DR. ALLEN answered in response to an inquiry as to the subsequent his-

tory that the patient had been kept upon anti-syphilitic treatment, and without local treatment the tumor had decreased in size, and had not shown any signs of pus formation such as heat, tenderness, redness or fluctuation.

DR. TAYLOR said he agreed with the view that it was a gummy tumor, and had seen such growths develop in syphilitic subjects at various points along the spongy portion of the penis.

DR. ALLEN presented a case of

PAPILLOMA OF THE UPPER LIP

which he thought was about to degenerate into epithelioma or sarcoma if it had not already done so.

Patient, Mrs. D—; aged 60; states that five weeks ago, possibly longer, she noticed a pimple in the center of the upper lip, pricked it, and found it rapidly increasing in size. It has given her no annoyance except from its appearance. She gives no family or personal history which would point to a predisposition to cancer. He had advised operation by removing the tumor with a knife and along with it a considerable area of apparently healthy tissue.

In regard to Dr. Allen's case of tumor of the upper lip DR. ELLIOT said he regarded it as a sarcoma.

DR. ALLEN said he had reported to the gentlemen who sent him the case in consultation that the growth was probably malignant and advised its removal, and asked to have the specimen sent him for microscopical examination, but had not yet received it.

DR. FOX then presented a case exhibiting

AN UNUSUAL FORM OF ECZEMA OF THE LIPS.

A young girl of eleven years had suffered for nearly two years from an annoying eruption around the mouth. The vermilion border of the lips was only slightly affected, but the skin adjoining was reddened and the elliptical patch presented a raised marginate border which was especially prominent beneath the lower lip. There was a slight tendency to scaling and to the formation of fissures, when the patch was allowed to become dry. The patient lived in the country, and her general condition was good. Although she suffered from occasional attacks of indigestion, at which time the skin about the mouth would swell somewhat and appear very red and angry. She was inclined to constipation, and at times there had been erosions upon inside of lips and side of tongue. Exposure to cold air always irritated the condition of the skin. As the result of varying plans of treatment, the patch had improved considerably but showed a marked tendency to relapses.

In the discussion which followed, DR. JACKSON said he had seen similar conditions produced from continued local irritation, and recalled the case of a car starter who suffered constantly from an eczema of the lower lip, which was kept moist from the whistle which he had almost the whole time in the mouth. Under suitable treatment and the employment of a smaller starting whistle, the man soon recovered.

DR. MORROW said this patient represented a class of cases in which eczema occurring in children was apt to be persistent from local causes. He had seen an oval or elliptical-shaped patch of eczema persist for months and even years in children, from the habit of protruding the tongue upon the lower lip or sucking the lower lip. This condition was apt to be aggravated by climatic changes, exposure to cold winds, etc. He had observed many such cases and found that the recovery was oftentimes spontaneous after the cause had been corrected.

DR. WEISSE regarded the condition as an eczema, and asked Dr. Fox in what condition the other orifices of the body were, and how long the disease had lasted. DR. Fox answered that no other region was affected and that the disease had persisted for two or three years.

DR. SHERWELL regarded the condition as one of eczema and thought the causation interesting in these eczemas and dermatitis. He had seen such a condition around the lips caused by a child sucking a veil. He said green veils were often worn by children who had disease of the eyes, and that arsenical preparations were used in dyeing and produced eczema or dermatitis when the part over the mouth became moist and remained in contact with the lips and chin, the proper nutrition of the tissues being interfered with.

DR. ELLIOT said he had seen a number of children affected with eczema of the lips which could be traced to a habit of wetting the lips and chin with the tongue.

DR. TAYLOR said the lesion always tended to be a superficial one, there being no infiltration or oedema of the tissues as in many other eczemas.

DR. FOX said he thought the gentlemen had lost sight of the point he made regarding the raised margin around the patch. He had never seen an eczema with such a raised solid rim or edge such as this case presented. He thought, however, that the fissuring and constant recurrence proved the eczematous nature of the affection, although he thought the patch extended too far for the tongue to reach. He remembered that the girl had had canker sores in the mouth and had suffered from stomach derangement.

DR. ELLIOT then presented a

CASE OF LICHEN PLANUS.

Patient was a male; age 42; chessplayer by occupation; in perfect general health; presented himself at the N. Y. Skin and Cancer Hospital, Dr. Bulkley's service, April 20, 1887.

Patient states that he was burnt superficially with vitriol on both ankles over seven years ago. Six and a half years ago lesions began to develop on the site of the burn on right ankle, and grew larger, new ones appearing, until they formed a uniform patch, covered with scales. A few lesions had appeared also on left ankle, but did not remain. The primary plaque on right ankle has persisted, growing larger slowly, up to the present time. Patient says he was in Europe last summer, and returned to this country in September. Immediately after his arrival here was attacked with a general pruritus, which continued until the eruption of new lesions occurred. About end of December he noticed the first lesions on the penis, but not until February, 1887, did any more appear. They then began coming out on the inner surfaces of legs and thighs, more especially about the knee and in the popliteal spaces. The plaques in these places are quite large and more or less confluent. Other lesions are found on the nates, a few on the body and forearms, but the majority are on the lower extremities. Patient has been under treatment for about a week, and already materially improved. The treatment has consisted in the use of Unna's ointment and Asiatic pills in rapidly increasing doses.

In discussing this case DR. MORROW said the diagnosis would be difficult from the present appearance of the eruption, were it not that there were to be found two or three typical papules, angular in outline with flattened summits, covered with a small scale and slightly umbilicated, which were characteristic. His own experience in the treatment of this disease is, that arsenic rarely succeeds in hastening the involution of the lesions so rapidly as

it has done in this case. He has tried two or three different plans of treatment with indifferent success.

DR. ELLIOT said he had found the treatment by Unna's ointment particularly good. He had recently had a case in the hospital entirely freed from the eruption in six weeks from the application of a two grain to the ounce solution of the bichloride of mercury to the whole surface of the body.

DR. SHERWELL said that a marked case of lichen planus had been recently seen by him in which change of diet with arsenic gave good results within a fortnight.

DR. BRONSON presented a

CASE FOR DIAGNOSIS.

The patient, a woman, for several years had suffered from an eruption and thickening of the skin in both axillæ. The disease had begun in the summer time, while she was suffering a good deal from "prickly heat," and was at first moist. At the present time there are no obvious signs of eczema, the eruption consisting of hard, conical papules, occupying apparently the site of follicles discrete toward the borders of the axillæ, but confluent in the central portions where the skin shows great thickening with an elevated, smooth but more or less mammillated surface. Here and there are little abrasions as though from scratching, but there is no desquamation and no apparent vesiculation. The only symptom of eczema now present is the itching. The disease is rebellious to treatment and has preserved its present aspect with scarcely any change for a long time.

In discussing the above case DR. JACKSON said he would regard it as a scrofuloderma, from the fact that the sebaceous follicles, glands, etc., were implicated.

DR. FOX thought it appeared to be an eczema developed in a scrofulous subject, resembling a scrofuloderma, of a warty-like nature. He regarded this as a favorite seat of eczema and scrofuloderma.

DR. ALLEN said he regarded the case as one of eczema, and has seen quite a similar condition, which he attributed to wearing thick rubber dress shields. An eczema has been produced resembling a neoplasm and there was considerable adenopathy. He thought the region favorable for this peculiar condition to take place when eczema once developed, from the activity of the sweat glands and the constant moisture of the parts, producing this peculiar thickened boggy condition of the tissues. No doubt the disease was modified from the fact of its development in a scrofulous subject.

DR. TAYLOR presented a case of

TUBERCULAR SYPHILIDE,

resembling the true serpiginous sypphilide presented at the last meeting.

DR. WEISSE said that this case had called to mind many similar cases which had been under his own care. It was a type of the disease much more common than that which had been described as the true serpiginous sypphilide.

DR. FOX said in regard to the frequency of the disease that he had in his Atlas of sypphilides photographs of three or four of the true serpiginous variety, but that in the past two or three years he had not met with a single case.

DR. JACKSON then read the paper of the evening entitled

ICHTHYOL AND RESORCIN; A STUDY OF THEIR THERAPEUTIC VALUE.¹

DR. MORROW said he had experimented with ichthyol and had come to regard it as a nauseous, disagreeable and for the most part inefficient drug.

¹ See page 215.

He had also used resorcin in epithelioma, lupus, chaneroid and other conditions, but had not been impressed with its advantages over older and better known drugs.

DR. LEWIS asked as regards the treatment of epithelioma by resorcin, whether there was simply a cuticle formed over the new growth, or if a cicatrix was formed which was absolutely firm. He said lactic acid had been mentioned as an efficient application in epithelioma, but that although the tissues healed up readily under this drug they soon broke down again.

DR. JACKSON answered that the cicatrix was firm and the diseased parts appeared to be destroyed by the resorcin.

DR. FOX said he thought that both ichthyol and lanolin had been introduced more from a commercial than a humanitarian object. As regarded resorcin he thought that in new growths it accomplishes a great deal and must be ranked with tar, chrysarobin and other drugs affecting the deeper tissues. He accepted much from the Germans and is duly thankful for what they give us, but he has learned that circumspection is necessary.

DR. PIFFARD said he was the first, so far as he knew, to employ ichthyol in this country. He had sent abroad for a sample when it was first brought to the notice of the profession abroad. He had used the drug as long as he could afford to, but he had had to stop using it or lose his patients. At a theatre he had recently taken up a programme and found a column devoted to ichthyol, and that it was extensively advertised as a popular remedy. It is advertised as the remedy with which Dr. Schweniger cured Bismarck of rheumatism, and in this country it is upon the same basis as cuticura. It is claimed to be obtained from boiling down fossil fish, but in reality it is not known what it is or just how obtained.

DR. ELLIOT said he had used ichthyol a great deal and had found it valuable in some cases, but on the whole his experience agrees with that of Dr. Jackson in all other diseases excepting eczema. Here it sometimes seems to act well.

DR. ALLEN said he had never used ichthyol. Resorcin, on the contrary, he had employed in several cases and with satisfactory results. He was now using it in two case of epithelioma which were doing well under it.

DR. KEYES asked in what strength.

DR. ALLEN said in these cases he was using a 10 per cent. ointment.

DR. JACKSON said he began with 30 per cent. He had also seen the good effects from resorcin in cellulitis from surgical wounds. He had seen paronychia promptly checked by its use.

Correspondence.

DERMATOLOGY AND KINDRED STUDIES IN GERMANY.

"Lymphorrhœa and Lymph-Abscess."

(*Wiener Med. Blätter*, 1887, No. 1.)

THE second one of the cases published by Mosetig-Moorhof, under the above heading, is of some dermatological interest, inasmuch as there occurred spontaneous rupture of an ectatic and ripe lymphatic abscess of the skin. Out of a fissure of the skin over the left tibia which corresponded to the orifice of a sweat gland, clear lymph welled up in sufficient quantity to

wet the patient's stockings and feet in a very short time. Instead of following Monod's method, which when deep enough cuts the lymphatic vessel across, rendering involution possible and checking the lymphorrhœa, M. used iodoform together with a compression bandage, and obtained closure of the fistulæ and complete cure in five weeks.

The Treatment of Burns.

Whilst burns of the first and the second degrees, especially when they are not very extensive, can be cured easily and quickly, those of the third degree, even when they do not implicate a very large surface of the body, cause great disturbance of the functions of the skin and of the entire system. Therapeutically we must endeavor to relieve the pain and to restore the skin under antiseptic rules. All the means heretofore recommended to relieve the unbearable pains of burnt and scalded patients, such as the hermetic closure of the injured parts by means of suitable bandages, or by oily or watery applications, or local anæsthetic measures, or the permanent bath which Hebra has lately recommended—either imperfectly accomplish their object, or fail to do it altogether.

Prof. Mosetig (*Wiener Med. Presse*, Nos. 2 and 3, 1887) has treated forty-eight cases of severe burns with iodoform, during the past five years and highly praises this method of treatment. The fear of iodoform poisoning he considers groundless, as neither he nor others who have employed iodoform for this condition, have met with ill results when ordinary precautions have been observed. The action of iodoform is a double one, being an analgetic and an antiseptic. According to the observations of Monod, which accord with those of Mosetig, the patient becomes quieter and in a condition better permitting of transportation within a few minutes after the application of the iodoform. In Mosetig's hospital service the patients thus treated lie quietly in bed free from pain. They recover more quickly, with less loss of strength, and have smoother scars than when otherwise treated. If, however, life cannot be saved, in any given case euthanasia is secured. Although the danger to life from oligocythæmia and nerve shock is not lessened by iodoform, it does lessen the danger of sepsis. In employing iodoform the author so applies it that only a small amount is used. He either does not apply the powder at all as such, or dusts it lightly over those parts that have been deeply burned and over which the skin is in a parchment-like condition. He advises iodoform gauze compresses, not the dry preparations which are found already made in the shops, holding much loose iodoform powder, but the kind which he himself first recommended, and which are prepared by impregnating bandage gauze which has been cleansed and freed from fatty matter, with an iodoform solution in ether.

Before being applied, any blisters or bullæ present must be opened and their walls cut away, and all dirt and foreign substances cleansed with absorbent cotton, wet in a $\frac{1}{2}\%$ solution of salt. Several thicknesses of the iodoform gauze are then cut to fit the burned part, and applied dry, so as evenly and entirely to cover in the region. Over this is to be spread an equally large or perhaps slightly smaller sheet of gutta percha paper, care being taken to avoid wrinkles, and finally over all a thin sheet of absorbent cotton extending beyond the other dressing or better still encircling the whole region of the body, and the whole secured by turns of a roller bandage. This simple and readily applied dressing is at the same time a permanent one and is to

remain in place as long as possible, that is so long as cleanliness permits and the temperature does not furnish an indication for its removal.

Simple wetting of the dressing is not an indication for changing it, but should the outer bandage become offensive it may be changed without removing the others. The iodoform gauze and gutta percha sheet should not be removed until the end of the second week.

Should fever make its appearance and point to septic trouble as a cause, the probability is that demarcation has taken place and the burn slough is coming away and there is retention of the secretion of the wound. The pus retention must be sought for and the slough removed with forceps and scissors, and fresh dressing applied as before.

The gutta percha dressing is very necessary and should never be omitted, for should the gauze dry and stiffen upon the burn it can only act injuriously. The secretions should dry only upon the outer bandage and not upon the inner.

By means of this permanent iodoform dressing, the contact of air and infection is prevented, and healing takes place in burns of the second degree usually under the first bandage. In burns of the third degree the slough is thrown off with slightly marked secretion, but when the latter is not the case, healing takes place by granulation in relatively shorter time and the scars are flatter and smoother than those resulting from the healing of non-aseptic wounds.

In burns about the face occlusion by the above method is not possible. The author here recommends the use of an iodoform salve (1 to 20) and over it the application of a gutta percha paper mask. Naturally the salve must in such case be applied in a layer of the thickness of the back of a case-knife and be renewed daily.

"On the Occurrence, Diagnosis and Treatment of Phimosis in Children."

(Wittelshofer, *Wien. Med. Wochenschr.*, 1887, Nos. 6 and 7.)

Congenital phimosis is commoner in children than is generally supposed, and leads to various disorders. Not only are such children never able to entirely empty their bladders, and so urinate incompletely, but there occur eczematous excoriations of the prepuce and the glans, eczemas of the genital regions, vesical catarrhs, hydronephroses and pyelitides. There have also been observed reflex disturbances and consecutive malpositions. We must, therefore, be on the lookout for the malady, and, if the prepuce can in any way be retracted, the fold of mucous membrane should be thoroughly and frequently cleansed. If the narrowed prepuce be irreducible by manipulation, W. recommends that force should not be used, but recourse be had at once to incision of the prepuce at the dorsum. He regards complete circumcision as entirely unnecessary and mutilating in these cases. To perform the operation bloodlessly and without assistance, the author uses the phymotome described and figured by him in the *Central lb. ft Chirurg.* The flaps of the foreskin are then united by sutures and an iodoform dressing applied. The unavoidable swelling of the penis is best met by lead water applications. On the third day the sutures may be removed, and a salve and bandage applied. Billroth's formula is the best that can be used: \mathcal{R} . Ac. Borac Paraffini, Cerae alb. āā 3.00, Ol. Amygdalæ 30.00, S. M. ft. ungt.

Local Cocaine Anæsthesia.

(A. Wölfler, M. Schustler, A. Frankel, M. Tillenbaum. *Wien. Med. Wochenschr.*, 1887, Nos. 2, 4, 5 and 11.)

In connection with his above publication upon cocaine anæsthesia, W. reiterates the statements which were the results of his former experience, and fortifies them with a large number of new cases. The other authors, above mentioned, agree with him in his conclusions, and they are all of opinion that successful anæsthesia depends almost entirely upon a correct technique of the injections. For small dermatological operations, such as those for the removal of lipomata, fibromata, atheromata and warts; for limited incisions, as for furuncles and abscesses; for phlegmons, circumcisions, buboes; for scraping lupus growths, etc., injections of a 5 to 10 per cent. cocaine solution will suffice. It must be done under the skin, yet not into the subcutaneous connective tissue, since anæsthesia will then be incomplete; nor yet into the epidermis and cutis itself, for it causes the formation of a painful vesicle. Complete anæsthesia may be thus produced over a limited area in 1 to 2 minutes; and the anæsthesia lasts about a quarter of an hour. When the inflamed portion of skin cannot be directly pierced on account of its great sensitiveness as in phlegmon, the injection must be done with a curved canula from the periphery, and the anæsthesia obtained in this way. Naturally the instruments used must be quite clean, and the solution must not contain fungi. For the latter purpose a few drops of a 1:5000 sublimate solution should be added to it. The field of operation must be disinfected in the same way. If we desire to anæsthetize a larger area, 1 per cent. solution is to be used, and a number of injections made; they being so arranged that their fields will form one large anæsthetic surface. Thus no more cocaine will be introduced into the body than is done when a single injection of a 5 per cent. solution is made. Strong solutions injected in considerable quantities are liable to cause a cocaine-intoxication. Wölfler has used amyl nitrite as an antidote to the drug. When about to curette for lupus the injection should not be made into the soft lupoid tissue, for the fluid would flow away without accomplishing its desired object. It should be thrown under the lupus infiltration.

Cocaine in the Treatment of Skin Diseases and Syphilis.

(S. Lustgarten. *Wien Med. Wochenschr.*, 1887, No. 12.)

Since cocaine, when applied to the unbroken integument, cannot come into direct contact with the nervous apparatus its usefulness is circumscribed, and it can only be employed when excoriation or maceration has loosened the horny layer of the skin. Moist eczemas with much secretion and violent itching will be the most appropriate for the exhibition of the remedy; then follow the eczemas of the genital regions and of the anus. The cocaine may be applied in the form of a 2 per cent. solution to the affected part twice daily. The ordinary treatment being meanwhile kept up, or the following salve may be rubbed in morning and night: \mathcal{R} . cocaini oleici 0.4-100, lanolini 18.00, olei olivæ 2.00. This ointment relieves the itching very thoroughly. The perineum and the genitals are to be thoroughly washed with soap and water, and the above salve or the drug in the form of powder applied. A further application of cocaine in dermato-therapeutics is where granulating

portions of skin or those which have been denuded of their epidermis are to be treated by caustics or with instruments, as in lupus exulcerans, flat epitheliomata, and wounds covered with sensitive granulations. Finally cocaine has been successfully used in the treatment of syphilis by injections of calomel or hydrargyrum oxyd. tannic. One or two divisions of the syringe of a 5 per cent. solution of cocaine is injected (0.01-0.02 of cocaine); the syringe is then removed, the needle being left in place, and the mercurial is injected. The pain is very much diminished by this procedure. The same thing may be done with arsenic injections.

HOROWITZ.

VIENNA.

Selections.

SYPHILIS AND NURSING.

IN the *Semaine Médicale* of December 1, 1886, Professor Fournier presented his views upon the course to follow in practice when there is a question of employing a wet nurse.

He graphically described how a nurse, to all appearances healthy, is procured for a healthy child, and at the end of a few weeks shows unmistakable signs of recent syphilitic infection.

The history of the case will be found to be somewhat as follows :

A woman nurses a child which is syphilitic. For some reason she is separated from this child, either from its having died or possibly by the order of a physician who has discovered the child to be infected. This woman continues her occupation of nurse and enters another family. She is examined, found healthy, and accepted. No manifestation of the disease is yet apparent. She is, however, syphilitic, and the disease is in its period of incubation. A few days or a few weeks later a chancre appears upon the breast, as the first manifestation of the disease contracted from the former child. Possibly the second child may present a chancre of the mouth, tongue or face. In this case the physician should treat both cases of syphilis and allow the nursing to continue. He should overcome the indignation of the family and their natural desire to send away the nurse. He should convince the family that this nurse is the only one who can with safety nourish the child, and that her breast is preferable to all other means of nourishment. The safety of the infant is at stake.

In case the child should not yet show signs of infection, nursing must be suspended and the child separated from the nurse to avoid all risk of subsequent contamination in case it has not yet suffered. An important point is to keep the nurse under observation and preserve her supply of milk. This is best done, according to Fournier, by the temporary employment of a young dog for the purpose. During the time the infant is nourished with the bottle or spoon. If it has the misfortune to show signs of infection, it must be returned to its nurse, from whom it no longer has anything to fear, and who will be a great assistance in its cure. If, on the contrary, the infant has happily escaped contagion and presents no signs of disease at the end of seven weeks from the time it was separated from its nurse, a healthy nurse may be procured, but not before this time, for fear the disease is still in its period of incubation.

If the physician is called into a family where he finds on the one hand a child suffering from hereditary syphilis, and on the other a nurse still apparently healthy, it becomes his duty not only to discontinue the nursing, but to see to it that the nurse is retained in the family and not discharged for six or seven weeks. This not only allows her to be kept under observation and treated if the disease develop, but prevents her from carrying the germs of contagion to others.

How are we to avoid the danger of procuring a nurse in the incubation stage of syphilis?

The first precaution to take is to choose one who has nursed only her own child, when, if no signs are apparent in either the mother or child, we may feel reasonably safe.

Unfortunately it is often difficult to find a nurse fulfilling these conditions, and we are forced to accept one who has already nursed from one to four infants. The medical examination under these circumstances only furnishes an illusive guarantee, for the disease may be latent at the date of examination. A medical certificate that the last child nursed was free from syphilis should be required.

Tarnier and Budin, in their recent publication, say that if the mother and child are both syphilitic, the mother should nurse the child; if from lack of milk or other reason she is not able to do so, giving the child to a syphilitic nurse is rational, but often difficult to carry out. In this case recourse is had to direct suckling from the female of some animal, or to artificial feeding with asses', cows' or goats' milk. Never should the physician consent to confide a syphilitic child to a healthy nurse, or to allow a nurse found suckling a child with the disease to continue doing so if she be still free, even if the parents insist upon it and the nurse is willing to take the risk. If the family will not follow the advice of the physician, he should, according to Fournier, without violating the professional secret of the child's disease, formulate and write down the treatment which he advises, and add to it that it will be absolutely impossible to continue the wet nursing. This should be dated and signed and handed to the father with a few words describing the situation, and a copy of the directions kept. When the mother is syphilitic and the child healthy, the mother only should give the breast, or the child be brought up artificially. No fear is to be entertained that the mother will infect the child (Fournier, Tarnier). If the milk itself does not transmit syphilis to the child, there are other ways in which the latter may contract the disease, notably when the breasts are affected. Instances in which nurses have contracted syphilis from infants and communicated it to their own offspring are unfortunately not rare.

Finally, if the mother is healthy and the child syphilitic by heredity, what is to be done? The mother can nurse the child without risk, for it will not communicate syphilis to her. This is known as the law of Colles, and can only be explained on the theory of the infection of the mother. As no symptoms of such infection are discoverable, Hutchinson thinks we should admit that the mother's syphilis has a nature peculiar to itself; is, in fact, mitigated and rendered mild, and while not manifesting itself by any outward sign, the infection has been profound enough to render her incapable of a new contamination. The importance of these facts may be augmented at this time when so much attention is being paid to vaccination and the attenuation of virus.

JUXTA-URETHRAL FISTULA OF THE MEATUS.

IN a paper recently published in the *Annales des Mal. des Organes Génito-Urinaires* Dr. Janin calls attention to a cause of persistence and relapse of urethral blennorrhagia, which is little known, and of which the following case serves as an example: A man having a urethral discharge for two years, which no treatment employed or care bestowed had succeeded in drying up, presented himself for examination. A transverse bridle or partition was found stretching across the urethra within the meatus, which separated two distinct orifices. The upper, which was the smaller of the two, terminated in a cul de sac; the other, situated below, was much larger, and constituted the meatus proper. In other words, there existed a slight deformity, characterized by a mild degree of hypospadias. On separating the lips of the meatus and pressing along the canal from behind forward, a small drop of pus is seen to ooze from a very small canal, opening upon the left lip of the meatus two or three millimetres behind the orifice. A fine Bowman sound could be passed six or seven millimetres into this narrow canal in a line parallel with the urethra, but without communicating with it. Dr. Janin treated this blind fistula by passing well into it a stylet heated to a white heat, with the result of almost completely obliterating it. A drop of a ten per cent. solution of nitrate of silver completed the cure. Since observing this case Dr. Janin has come across a number of similar ones. These fistulae, which, by the way, are relatively frequent, and are met with especially in the subjects of congenital malformation of the urethra as in the case cited, become the point of refuge for micro-organisms after those in the more accessible portions of the urethra have been destroyed by appropriate treatment. In similar cases Drs. Diday and Doyon recommend cauterization with the aid of a metallic needle or the end of a copper wire, which is introduced into the passage while the other extremity is heated in a flame. A piece of cardboard, pierced by the needle, forms a screen and allows of the approach of the flame without danger of burning the skin or mucous membrane. Dr. Diday has also succeeded in effecting a cure by applying nitric acid to the canal by means of a fine piece of wood. A very long tract, especially if tortuous should be incised, as is done in anal fistula—*Journal de Médecine*, February, 1887.

BROMIDE ERUPTIONS.

A PATIENT entered Dr. Besnier's service, at the St. Louis Hospital, presenting an eruption upon the face characterized by small, soft masses, which at first suggested a lupus of rapid development, or a condylomatous syphilide. These lesions were at certain points accompanied by the production of bullæ, in which the fluid appeared as though confined by a light meshwork, and gave by their consistence the sensation of a soft sponge. From an anatomical standpoint it was that form of pemphigus which is called vegetans. This abnormal form of eruption suggested a toxicodermia, and the history obtained tended to confirm this theory, in showing it to be due to the bromide of potassium. This patient suffered from a severe form of heart disease as well as from a gastric lesion, which was probably ulcerative (he having had several attacks of hæmatemesis). Larger doses of the bromide had been given than could be supported, owing to the disease of the stomach, as well as to an abnormal condition of the kidneys. Examination of the urine showed it to contain a considerable quantity of albumen. It should be remarked in pass-

ing that an examination of the urine should always be made when large doses of bromide are being given, and this is equally true of other drugs in large doses. It might happen that unless one knew of the possibility of such eruptions being due to the drug, its administration would be continued, to the detriment of the patient. Dr. Jacquet, an interne in Dr. Besnier's service, has published a description of a bromide eruption in the *Annales de Derm. et de Syph.* The lesions, which appeared in a vigorous man, occupied the scalp, the face, the neck, upper dorsal region, and the chest. They were of all dimensions, and occurred as papulo-pustules, from the size of a pea or a small nut, of a round or ovoid form, having a red base, and not indurated. They were produced by a raising up and distension of the epidermis, and showed by the transparency of their wall a grumous pus within the tumors. Other lesions appeared as tumors, raised half a centimetre and more from the surface, and as large as a half-dollar piece. Their base, soft to the touch, was covered with a bluish-colored epidermis. In the centre of the patch was a slight depression, and a number of gaping orifices, bordered with the swollen and bluish epidermis, were to be seen scattered over its surface.

Pressure upon the edge of the tumors was very painful and caused pus to flow from each of these openings. The large tumors were like so many small purulent sponges, from which the spontaneous oozing was increased by the least pressure. There existed moreover, no infiltration of the derma or the hypodermis at the base of these lesions; all was above the surface. The patient who presented these lesions had taken, during eleven days, two spoonfuls a day of a solution containing a mixture of the iodide and bromide of potassium in the strength of fifteen grains for each spoonful. What points more to the bromide than to the iodide as a cause, is the fact that at no time were there present symptoms on the side of the mucosa, such as coryza, etc. Further, the eruption plainly conformed to the description which authors, especially Raposi, have given of the bromide eruption, and finally the course appeared to agree with the mode of elimination of the bromide, which is slower than that of the iodide. They continued to appear and became more marked for ten days after ceasing the drug.—*Journ. de Médecine*, Paris, February, 1887.

TREATMENT OF VIRULENT BLENNORRHAGIA BY ANTISEPTIC INJECTIONS.

DR. HAMONIC (*An. des malad. des org. genito-urinaires*), after distinguishing a simple or inflammatory urethritis consecutive to any irritant cause, from a virulent blennorrhagia, characterized by the development in the superficial portions of the urethral mucous membrane of a special micro-organism—the gonococcus—shows the necessity for and the efficacy of antiseptic treatment in the latter of these two affections.

In blennorrhagia *gonococciana*, which always has a period of incubation of a few days, antiseptics are not employed in the beginning, because the microbes, not having as yet penetrated deeply beneath the epithelial cells of the urethra, are easily reached and destroyed by a mild injection. Later, however, as the colonies of microbes penetrate more deeply into the thickness of the mucous membrane, they are dislodged with much more difficulty.

The more readily the parasiticide can be brought into contact with the gonococcus, so much more rapid will be the cure. In the beginning of a

blennorrhagia, Hamonic employs antiseptics which are but slightly irritating, such as sulphate of quinine, in the following mixture (not a solution):

R Bismuthi subnit.	gram 5
Quinine sulphat.	" 1
Aquæ rosæ.	" 130

These injections are to be given daily, with the usual syringe, into the anterior urethra, for if the posterior urethra is also affected, we must have recourse to instillations. It is advisable to use along with the quinine injections pure yellow sandalwood oil in the dose of eight to ten capsules daily.

In this manner the cure will be complete and radical in twelve days at most.

The use of iodized glycerine (neutral glycerine, 125 grams; tincture of iodine, 75 centigrams;) or iodoform held in suspension (glycerine, 200 grams; finely pulverized iodoform, 2 grams;) are also at times followed by excellent results. Among other, but slightly irritating antiseptics, which must be employed in cases of very painful inflammation, the author mentions a one per cent. boracic acid solution, infusion of walnut leaves, etc.

Solutions of nitrate of silver and phenic acid, both excellent antiseptics, the author considers as too caustic, and naturally very painful. Consequently, he gives preference to the above formula.

Among the irritating antiseptics applicable to long-standing and rebellious cases, he places chloride of zinc, permanganate of potash, and corrosive sublimate. These therapeutic agents are almost always very painful, but they should never be caustic in their effect. The first two substances, chloride of zinc, and permanganate of potash, are employed in solutions of 25 centigrams to each 125 grams of water, attempting progressively to habituate the canal to solutions containing 50 or 60 centigrams, and even in certain cases, a gram of the active substance to the same quantity of water.

Having had repeated occasions to employ permanganate of potash solutions in the treatment of bleennorrhagia, we can affirm from personal experience that the strength employed by Dr. Hamonic is excessive. In greater strength than 10 centigrams to 150 grams of the vehicle, permanganate is already irritating, and it seems to us that a twenty-five-centigram solution can with difficulty be tolerated. It would appear, also, that no prudent practitioner would employ a solution of greater strength than 10 centigrams to 150 grams of vehicle, in the early treatment of acute cases, and from 15 to 20 centigrams to the same quantity of vehicle in chronic cases.

As regards corrosive sublimate, Hamonic employs a solution in the exact proportion of 1 to 8,000, or 1 to 5,000, and in exceptional cases, 1 to 3,000. In a few rebellious cases he has employed the following injection:

R Sol. of corrosive sublimate (1-5000)	130 grams
Permanganate of potash.	40 centigrams

In conclusion, the author absolutely rejects the use of oxygenated water, which, he says, constitutes a very painful method, and one which is more than likely dangerous.—V. M., in *Uniao Medica*, December, 1886.

TUBERCULAR CONTAGION BY WAY OF THE GENITAL TRACT.

In 1882, Colmheim pointed out the possibility of tubercular infection through the genital organs. Verneuil in 1883 admitted direct tubercular

contagion in this way. Balbes some months later encountered tubercle bacilli in the urine of a person affected with tuberculosis of the genito-urinary organs. Cornil a little later observed a case of tuberculosis of the bladder contracted by direct contact in sexual intercourse. In 1884, two other cases were communicated to the Hospital Medical Society. Later, Richor observed in the case of a soldier transmission of the disease through coitus with an infected woman. In 1885, Bories published another similar case in the *Revue d'Hygiène*. Now Drs. Fernet and Derville, to further establish the opinion that contagion through direct transmission of tuberculosis of the genital organs in sexual intercourse is possible, have communicated to the Clinical Society of Paris two new observations.—*Gazetta degli ospitali*, Naples, December, 19, 1886.

In the February number of this JOURNAL will be found an interesting communication on *circumcision* and *tuberculosis*. Elsenberg, a Polish physician, relates (*Monatshefte für prakt. Dermat.*, No. 5, 1886) that a priest who had tuberculosis of the larynx as well as of the lungs, and whose sputum showed bacilli, had circumcised an infant. It was found at the age of five months to have the wound of the penis transformed into an ulcer covered with a yellow adherent deposit. The inguinal glands were much enlarged on both sides, and from an opening on one side an opaque serous fluid escaped which contained caseous particles. A large fluctuating abscess was found in the region of the mastoid on the right side. The abscess was opened and the cheesy glands were removed, but the child died of erysipelas and tetanus. Tubercle bacilli were found in abundance in the ulcerated prepuce as well as in the caseous lymphatic gland.

BLENNORRHAGIA AND ITS TREATMENT BY SUBLIMATE INJECTIONS.

DR. FERREIRA (*Uniao Medica*, December, 1886), after referring to a previous article which he had written upon the advantages of permanganate of potash in the treatment of blennorrhagic urethritis and vaginitis, speaks of the conditions under which other agents should be employed, and especially corrosive sublimate.

The more microbiological studies are pursued and perfection approached, the greater grows the confidence in germicide treatment.

Experiments and researches apparently prove the parasitic nature of gonorrhœa, which, from now on, must be considered as founded upon Neisser's gonococcus.

Dr. Fantini was the first to employ this agent in the treatment of blennorrhagia, in 1881, having observed that a solution of 1 to 20,000 of sublimate killed the gonococci.

Martineau, in his service of the Lourcine Hospital, obtained excellent results from its use in blennorrhagic folliculitis of women. He first employed a solution of 1 to 500 for urethral injection, but, having observed in some cases that cystitis was produced from the penetration of the injections of sublimate into the bladder, he substituted for it suppositories containing four milligrams each of bichloride of mercury, reserving solutions for vaginal injections. Dr. Constantin Paul made use of solutions of 1 to 20,000 to great advantage, and twenty of the patients treated by Dr. Chameron with the same strength of solution were radically-cured in a remarkably short space of time. From his extensive practice and observations Dr. Constantin Paul

advises the employment of a bland liquid, in order not to prevent the expansion of the canal, so that the antiseptic agent may penetrate the innermost recesses and crypts of the mucous membrane. A high temperature of the solution is advantageous in that it aids to distend the orifices of the glands of the urethral canal, in which the gonococci hide away, so that they may not escape the action of the germicidal liquid. He employs the following formula :

R Van Swieten's liquid	gram. 10
Aque.....	" 190

M. S.—Three injections daily, after urinating and washing the extremity of the penis with the same solution.

The author cites three cases from a number in which he has carried out this treatment in his service in the Misericórdia Hospital in Rio de Janeiro. The cure was complete in from twelve to fifteen days, and, on the whole, the method of treatment was regarded as highly satisfactory.

SOME DIAGNOSTIC POINTS IN STRICTURE.

ALTHOUGH the diagnosis of stricture of the urethra appears like a simple matter, it is certain that errors are frequently committed, even by experienced physicians. It is especially common to see the diagnosis of stricture made, when no stricture exists.

A boy of sixteen years, who entered the service of Professor Gnyon at the Necker Hospital in Paris, furnishes an example. The history showed that his mother was tuberculous. At the age of eleven he suffered from incomplete incontinence of urine and passed bloody urine. Six months before entering the hospital he sustained a traumatism of the penis.

When an attempt was first made to pass a sound in order to give electrization to the parts, an obstacle was met with which strongly suggested stricture; still, excepting for the traumatism, which had been severe enough to cause hæmaturia, there was nothing in the case to account for a stricture of the urethra, strictly speaking. On the other hand, being the offspring of tuberculous parents and having had incontinence of urine and frequent desire to micturate, he presented all the conditions which should make one think of spasm of the urethra, and in fact it was soon possible to pass a large metallic instrument and show this to be the case. We could in such a case pre-suppose the non-existence of stricture in conforming to two principles which should ever guide to the diagnosis in similar cases. It can be said, in fact, that we are not justified in considering a case one of stricture in a patient who has not at some time had either a gonorrhœa or has sustained a traumatism or has had an ulceration of the urethra. The last mentioned condition, it is true, is very rare and should hardly enter into consideration. A second and more important point is that in a general way a stricture should not be diagnosed as such until it has been passed, while, as a rule, the very opposite is done. It is only in passing a stricture that we can recognize its characteristics, by the grasping of the instrument, and especially by the sensation caused by the multiple rings which constitute the lesion. The sensation is communicated by the instrument both in its introduction and withdrawal, but can only be well appreciated when the olive-shaped bougie à boule is used. Impassable strictures must, of course, be diagnosed by other means. When there has been traumatism, as is often the case in impassable

stricture, a difficulty in diagnosis often arises from its association with gonorrhœa or the effects of coitus. In severe gonorrhœa the inferior wall of the urethra loses its extensibility and rupture may result. There is a variety of traumatism which results from what Dr. Guyon calls the *faux pas* of coitus, due to a faulty entrance in the act of copulation and resulting in a slight rupture of the urethra, followed by a discharge of blood. This may, more frequently than is generally supposed, lead rapidly to stricture.

It is then not because a patient complains of an alteration in the stream of urine that we should hasten to make the diagnosis of stricture. In examination a good sized bougie à boule should first be tried. The differential diagnosis with spasm is important and founded on the following symptoms: Whenever there is painful and difficult urination frequently repeated a spasm may be found as the cause. These patients are often subject to a painful affection of the bladder, particularly tuberculosis. It must be borne in mind that the spasmodic stricture offers resistance to the entrance of instruments, but not to their withdrawal, and once passed the stricture for the time being ceases. Again, spasm has the peculiarity of resisting soft instruments and giving way to solid ones. Spasmodic strictures are frequent and especially to be met with in narrowing of the meatus, cystitis, and many other affections.—*Jour. de Med. et de Chirurg.*

CLINICAL OBSERVATIONS ON "INDURATION" IN THE PRIMARY LESION OF SYPHILIS IN WOMEN.

At a recent meeting of the Royal Medical and Chirurgical Society Dr. W. E. Cant gave the following results, founded on about 3,300 cases examined in the Royal Albert Hospital, Devonport, during a period of six and a half years. In contradistinction to the generally accepted fact that in men induration is, as a rule, well marked, it is so in women far less generally. The induration which is described as being circumscribed, limited to the base of the sore, and clearly marked off from the surrounding tissues in men, is in women about as often as not diffused a considerable distance into the tissues around, often very widely, not sharply defined from the surrounding tissues, nor circumscribed in the base of the sore itself. The most typical form of primary sore, with its induration resembling a disk of cartilage set in surrounding soft structures, described as being frequent in men, is seldom met with in women. Every variety as to the degree of development of the induration is met with in women; but there is a large proportion in which it is very slight (about one-third). In some of these slight cases it is impossible to affirm that there is any thickening at all present, and there is a small number in which none exists throughout the whole course of the sore. Induration is present in the early stage of the sore only in a small proportion of cases. The time of its occurrence in the course of the sore varies greatly; it may occur at almost any period of its course. It becomes most marked and developed towards the middle and latter part in many cases. Tables of cases of primary sores, grouped according to their clinical character, and showing "when first apparent," "characters at earliest period," etc., and also of five cases of infecting primary sore in which there was no induration, were appended to the paper.—Dr. Drysdale agreed that induration was much less common in women than in men. He thought we ought not to speak of "hard sores," but of "the primary lesions of syphilis," of which some were

hard and some soft. It was less easily traced in women, because in their case the primary lesion was often trifling; it caused little or no pain, and they did not remember anything about it. The primary lesions in women were not different from the primary lesions in men, except in so far as they were affected by the tissues in which they occurred. Those, for instance, in the lip were wooden in hardness. He had been a pupil of Fournier, but he quite expected to hear what Mr. Cant had said. Vigo, in 1510, and Fallopius, about 1555, had noticed the hard tissue round the sore, and from that time much stress had been laid upon it; but it was to be remembered that in experimental inoculation the primary lesion had very little hard tissue round it; it was a mere papule. He could have wished to hear more of their position. For his own part, though he knew that there had been hard sores on the os uteri observed in Fournier's *clinique*, he had never himself found one, nor on the vagina.—Mr. Harrison Cripps was of opinion that the induration or non-induration was a question of locality; it depended on the anatomical nature of the tissues affected; induration was found in erectile tissue, and in the lip; and in the lip, induration often followed injuries which had nothing to do with syphilis. He had seen a case of chancre of the finger in which there was no induration, but which was followed by well-marked constitutional syphilis. He had noticed several similar cases since then, and his impression was that primary lesions, except on the lip and penis, were not indurated from beginning to end.—Mr. Holmes said that, in his opinion, this paper was one of the highest value, for it differed from almost all the teaching on the matter of syphilis, inasmuch as it was not an indistinct record of memories, but a distinct record of facts. Such opinions as were stated in the paper were summaries of facts. And it was a matter, too, of great importance that these seventy-two cases which Mr. Cant had tabulated were under close clinical observation from the very beginning of the disease; the time of inoculation could be determined within a day or so, not on statements of the patients, but by medical observation, and the time, method and extent of the induration also determined accurately, and the test of symptoms of constitutional syphilis could be closely applied. The conclusions were not the results of impressions such as many had been guided by. They certainly agreed with what he had gathered from his own comparatively very small experience.—*British Med. Journal*, February 12, 1887.

ON THE INFLUENCE OF IODIDE OF POTASSIUM UPON THE ELIMINATION OF MERCURY.

SOUCHOW (*Wratsch*, No. 44, 1884), concludes:

1. The elimination of mercury by the urine begins later and the quantity of mercury eliminated is comparatively smaller, in cases where the patient is taking at the same time iodide of potassium.
2. The iodide of potassium administered during or after a mercurial course lessens at once the quantity of mercury eliminated daily.
3. Consequently, far from contributing to the elimination of mercury as Hermann, Melsens, Michel and others thought, it seems to prevent this elimination and would have no utility in poisoning by mercury as Melsens thought. The author draws his experience and observations from numerous patients in the Syphilitic Clinic of Professor Tarnowski.—*Bulletin Gén de Thérapeutique*, 15 February, 1887.



No. 2



No. 3

No. 1. 2d. Delinquent case of Syphilis. Foster.
No. 2. 3d. Delinquent case of Syphilis. Syphilide

JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

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VOL. V.

JULY, 1887.

No. 7.

Original Communications.

HERPES ZOSTER: ILLUSTRATION OF CASE WITH UNUSUAL
DISTRIBUTION OF LESIONS.

BY

A. R. ROBINSON, M.D., Etc.

THE patient was a girl, aged $2\frac{1}{2}$ years. Previous health not good, having suffered much from intestinal derangements of considerable severity, gastro-enteric catarrh and entero-colitis. The eruption commenced on the upper part of the thorax, front and back, and within twenty-four hours extended down the arm to the tips of the fingers. The lesions were situated upon both the anterior and posterior surfaces of the arm and hand. There were only a few lesions in the palm, a greater number appearing upon the back of the fingers and some between them. The disease ran the usual course, the lesions disappearing at about the same time as in the other case. The drawing was made at an early stage of the disease before the vesicles were well formed in the region of the hand.

This case is reported on account of the unusual situation of the eruption upon the palmar surface, the lesions extending to the ends of the fingers.

I have drawings of two other cases, in one of which the eruption appeared simultaneously upon both sides of the face, cheeks, ears and upper part of neck.

In the other the eruption situated upon the right arm was preceded for two days by neuralgic pains in the forearm and hand. All of the lesions were situated below the elbow and

extended to the very ends of the fingers, appearing both upon the palmar and dorsal surfaces. The disease ran the usual course and disappeared after a couple of weeks' duration.

CASE OF TUBERCULAR SYPHILIDE.

BY

R. W. TAYLOR, M.D.

THE chromolithograph shows clearly the resolute tubercular syphilide upon the arm of a man who had been syphilitic nine years. Though patches of large extent on the body had been thus attacked, in no spot had ulceration taken place during the period of three years. The lesion was essentially an infiltration of the entire derma attended about the body with slight, and about the elbows and knees with considerable exfoliation. Two modes of increase of this syphilide were observed in this case. First, the patches increased at their margins by festooned crescentic borders, and thus came to involve large surfaces. Secondly, a number of small patches developed around a primary tubercle, all of which fused together. This latter mode is well shown in the picture as occurring on the elbow. The lesion might be mistaken for psoriasis if viewed alone. The atrophied condition of the centre of the patch which was nine inches long by six wide, its deep pigmentation, the peculiar outlying tubercles which involved the whole thickness of the skin, and were moderately exfoliative pointed to syphilis as the origin, which the history of the case and the co-existing lesions fully confirmed.

SUPRA-PUBIC CYSTOTOMY FOR VESICAL TUMORS AND LARGE CALCULUS; A RECORD OF THREE CONSECUTIVE SUCCESSFUL CASES, WITH COMMENTS UPON VESICAL SUTURE AND A SUGGESTION FOR DRAINAGE.¹

BY

E. L. KEYES, M.D.

THE whole question of supra-pubic cystotomy is being worked out anew at the present day under the impulse given to it by Petersen's suggestion of rectal inflation combined with distention of the bladder. My present object is

¹ Read before the American Association of Genito-Urinary Surgeons.

to contribute a few cases to the literature of the subject and such conclusions upon mooted points as my study of these cases has enabled me to draw. I have no purpose to make this article exhaustive from a literary standpoint. The time is not ripe for final generalization, for, although much has been written, the profession is still far from being in accord upon many points, and very essential ones, such as drainage, vesical suture, dread of the peritoneum and how best to avoid that much respected membrane; whether or not to distend the bladder or rectum: if they are distended, to what extent the distention is to be carried; whether to ligate all vessels before opening the bladder or not; whether to dress the wound or leave it open; whether to use antiseptics or not; what position the patient is to assume after the operation.

Until there is more accord upon these various points, generalizations will be unprofitable and unconvincing. The current literature of the day abounds in isolated expressions of opinion from the pens of numerous operators upon one or more of the points I have cited. My experience has given me certain impressions in regard to some of them, and these I shall here record.

The best general collections of cases of vesical tumors, so far as I know, as written in Germany, France, England and America, are those of Stein,¹ Thompson,² Küster³ and Guyon.⁴ The study of the supra-pubic section is to-day drawing away from its consideration with reference to stone and foreign bodies and rather concentrating upon its applicability to the treatment of vesical growths, and it is, I believe, in this direction that the future of the operation mainly lies, although it will still be called for in cases of large stone, certain foreign bodies, and probably in some cases for exploratory diagnostic purposes.

My personal impression in regard to the safety and value of supra-pubic cystotomy was in former days very low, because I first employed it upon cases of a desperate nature—two in number—both of which turned out unfortunately, as they might well have been expected to do by any method. In another case, the conditions were more favorable, but the result, again unfortunate, turned my attention from the subject, and biased my judgment

¹ Tumors of the Bladder. Wm. Wood & Co., N. Y., 1881.

² Tumors of the Bladder. Churchill, London, 1884.

³ Über Harnblasen Geschwulste und deren Behandlung. Sammlung Klinischer Vorträge, 267, 268.

⁴ Sur le diagnostic et le traitement des tumeurs de la vessie. Ann des Mal. des Org. Genito-Urinaires, Nov., 1886, p. 651.

against it. These cases I have recorded, and finding, upon making a recent statistical study¹ that, up to the spring of 1885, the least general average of mortality after the operation was 24.40 per cent., while the average mortality in the earlier days from the old-fashioned operation had been 30 per cent., I again was unfavorably impressed, particularly as to the gravity of the operation when compared with other methods of getting at the inside of the bladder.

These statistics, under the new method, are now improving every year, and some ardent advocates of the new operative method are seeking to extend the application of supra-pubic cystotomy, and to urge its performance in every case, young or old, in which the bladder has to be opened.

Such a generalization I consider unwise, and likely to lead to misuse of the operation, and ultimately to interfere with the undoubted value it possesses.

With our present knowledge, I think that the adoption of the operation for young children is absolutely unjustifiable. When we turn to Thompson's well-known statistical table of 1,827 cases, collected from the hands of all general operators in England, and find that below the age of five years one infant died after lateral lithotomy out of every $14\frac{33}{100}$; or to Coulson's table of 2,972 cases (a condensation of a number of statistical tables) and find that after the same operation below the age of ten years one child died out of every $13\frac{8}{100}$,² how distressing is the contrast, and how wearisome sounds Bereskine's laudation of the high operation in children at the Irchik Hospital of Moscow as recently published.³ This gentleman reports 59 operations upon infants, with 8 deaths, one in $7\frac{37}{100}$. How old the oldest one was I do not know, but 33 of the children were less than five years old, and out of these seven died—one in $4\frac{71}{100}$. This almost looks like unjustifiable manslaughter, and yet Mr. Bereskine praises the high operation for infants. How different is the recent report of D. F. Keegan⁴ upon the results of litholapaxy in male children. This gentleman gives a table of 58 cases of boys operated upon by litholapaxy—all in one sitting, save one case, which required three. The youngest boy was $1\frac{3}{4}$ years old, the oldest 14—the average age $6\frac{1}{2}$. The smallest stone weighed five grains, the largest 700 (this in a boy $9\frac{1}{2}$ years

¹ Art. Urinary Calculus, International Encyclopædia of Surgery, Vol. VI., p. 206, 1886.

² Article Urinary Calculus. International Encyclopædia of Surgery, Vol. VI. p. 204.

³ Cited in *Aun des Mal. des Org. Genito-Urinaires*, April, 1887, p. 241.

⁴ London *Lancet*, December 4, 1886, p. 1068.

old). The average weight of the stone was $108\frac{1}{2}$ grains. Out of these 58 cases every one recovered, except one boy of 4.

Tables that have been published by Bigelow, by Thompson, by Guyon, by myself and others, show how greatly superior litholapaxy is in its statistics upon middle-aged and old men, yielding less mortality than any cutting operation.

My conclusion is, therefore, that at the present day, in the case of stone, litholapaxy is the proper operation at all ages. When, for any reason, this operation is not practicable, perineal lithotomy is the operation of choice, for small and moderate-sized stones. The high operation is suitable for large stones, encysted stones, some foreign bodies, and for most tumors, and perhaps a few other exceptional cases.

A case of presumed vesical tumor (Case I.), sufficiently obscure to make it wiser to explore the bladder thoroughly through an opening above the pubis rather than through a perineal incision, required operation at my hands in the autumn of 1886. The result was brilliantly successful. Within a few weeks another very obscure case (Case II.) which had already been cut twice in the perineum by able hands, demanded exploration from above, if anything at all was to be attempted. This case also met all my expectations, and succeeded without a complication, to be followed almost immediately by a stone case, the stone being so large and the patient so seriously ill that any operation except the supra-pubic was out of question. This case also (Case III.) recovered most satisfactorily, and I find that some of my former prejudices have vanished, and that I feel inspired by a new confidence in regard to the operation, so far as its successful applicability to grave disorders within the bladder is concerned, disorders beyond the safe reach of other means, while my fears as to the direct danger of the operation have dwindled very greatly.

CASE I.—I operated, September 26, 1886, on a gentleman of 49, by the supra-pubic method, taking from his bladder the tumor which I here show. When removed, it was as large as a small orange, nearly spherical, about two inches in each of its diameters. The tumor was quite soft when removed. Professor Biggs, of the Carnegie Laboratory, examined it and reported it to be a villous papilloma, composed of a richly cellular connective tissue basis, with numerous closely set, long-branched processes extending out from it. These processes are composed of a very vascular connective tissue covered over by several layers of epithelium.

This gentleman had been under treatment by Dr. Alfred

Post, and later by Dr. Van Buren, finally coming under my care. For fourteen years before his operation, he had suffered from vesical symptoms, prominent among which were pain, recurrent attacks of cystitis and intermittent hæmaturia. The hemorrhages lasted at first only a few hours, later a number of days. The first attacks always commenced at the end of the day, after exercise. Sounding at the hands of each of his surgeons failed to detect stone, or any tumor that could be appreciated, and such instrumentation was usually followed by an aggravation of all the symptoms.

He was treated in all the usual routine ways until finally, during the summer of 1886, his general health became greatly deteriorated, the pus in his urine increased, and vesical soreness became more pronounced. On July 2d, during a search for tumor, a minute shred of tissue came away in the eye of the searcher. Under the microscope, I found this to be a clump composed of several layers of apparently healthy epithelium. A severe attack of cystitis followed this search and the patient was sent to the country, put upon Poland water, milk diet with anodynes and tonics, and kept at rest, as preparation for an operation when his condition permitted, as I considered the diagnosis of tumor established. The age of the patient, the continued hemorrhages, the bit of epithelium brought away by the searcher made me dread an epithelioma, but the long duration of the symptoms encouraged a hope that the growth might prove to be benign.

At the operation I was assisted by Dr. S. Alexander, Dr. Geo. R. Lockwood, Dr. Welcome T. Alexander, Dr. Brewer and Dr. Blackwell. About twelve ounces were thrown into the rectal colpeurynter (Guyon's)—and about eleven ounces of hot borated water into the bladder—which it was found impossible to clean out thoroughly by injections on account of the free flow of blood. The walls of the bladder, after the recti had been separated and the peritoneum rolled up in its layer of fat, was held up by two loops of silk, between which a free incision was made. Hemorrhage from the interior of the bladder was profuse, and a soft red tumor at once presented in the vesical incision. Exploration by the finger established the fact that this tumor was pedunculated, the pedicle being about as large as the finger and inserted on the right side of the base of the bladder near the orifice of the right ureter. The loop of a thin wire was passed over the tumor, and it was slowly screwed down until the tumor separated. The searching finger now recognized that nearly the entire base of the bladder was covered by soft velvety villousities which bled alarmingly. These were all rapidly scraped away with a sharp uterine curette. This curetting was very extensive, almost severe, in its application, all the diseased surface being thoroughly gone over several times. After the

scraping the bleeding moderated somewhat, but not sufficiently to get a good view at any time of the base of the bladder. Hot irrigation quieted it still further, and after it was decided that there was no arterial hemorrhage from the point at which the main tumor had been attached to the bladder a perineal tube was introduced and the wound in the bladder sewed up with carbolized catgut in continuous suture, the outer surfaces of the bladder being slightly turned in upon each other, and the sutures not being allowed to penetrate in any instance through the mucous coat of the bladder. The abdominal wound was sutured deeply with boiled silk (out of alcohol and corrosive sublimate 1 in 1,000), a deep drainage tube was passed between the muscles into the prevesical space, and another superficial one placed at the upper angle of the wound. Iodoform and borated cotton with a bandage constituted the dressing.

Bleeding ceased at once. The bladder was irrigated twice a day. Reaction was very moderate. No urine ever escaped through the abdominal wound. At the end of a week the temperature ran up for a few days from the formation of a little pus in the prevesical space, but no urine was mixed with it. The perineal tube was removed during the third week, and at the end of this week the patient left his bed, and in less than a month he was out. On October 22d he passed clear urine, holding it four hours. In May, 1887, I saw the patient. He was satisfactorily well, and had grown quite fat.

CASE II.—A German silk-weaver of 28 came to my wards in Bellevue Hospital, November, 1886. Four years previously his troubles had commenced as frequent painful urination with a sensation of burning at the end of the act.

In 1884, perineal cystotomy was performed upon him in Albany, but no appreciable relief followed. In 1885, the perinæum was again opened in Bellevue Hospital by one of the surgeons, and the bladder explored. He was discharged unrelieved.

I searched his urethra and bladder and found nothing. The microscope excluded pyelitis, no tumor could be felt in the bladder, but as the urine was full of pus and occasionally contained blood, and as the intervals of urination were reduced to an hour or less, night and day, and the patient was in manifest distress, I concluded to explore the bladder through a supra-pubic opening, and to do whatever seemed best.

November 30th.—The operation was conducted as usual. Bleeding was controlled entirely before opening the bladder. After the vesical wall had been incised, about one-third of the vesical mucous membrane was found to be the seat of a finely villous growth, or rather a granular studding of the mucous membrane was brought into view, bleeding at the lightest touch. This morbid appearance occupied the base of the bladder at the

urethral orifice, spread over all the anterior wall, a portion of the upper wall and a part of the trigone. The line of demarcation between the healthy and diseased membrane was made quite distinct by placing the patient in Trendelenburg's position. There was no ulceration in any part, and there was no suspicion of tubercular disease in the case. The lungs, testicles, seminal vesicles, and prostate were normal.

All the diseased membrane was thoroughly scraped with a sharp curette. A perineal tube was passed, in the manner about to be detailed in this article. The bladder was sutured with catgut, but no suture was applied to the external wound, which was left freely open, being, between the muscles as well as superficially, packed with iodoform gauze and cotton. The material scraped from the bladder was sent to a pathologist for examination, but unfortunately was misplaced, allowed to dry up, and no examination was attempted. Slight leakage of urine occurred through the abdominal wound after a few days, but spontaneously ceased. The perineal tube was removed in the third week. The abdominal wound closed by granulation in the fifth week. The patient was up and about the wards doing well, urinating six to ten times in the twenty-four hours, and was finally discharged (for misconduct) in the ninth week—very greatly relieved but not absolutely well.

CASE III.—On December 24, 1886, a gentleman of 44 came to me from the West complaining of frequent, difficult painful urination from which he had suffered during his entire lifetime. He was a pitiable object urinating night and day at intervals varying from fifteen minutes to two hours. His urine was a curdy mixture of purulent shreds and free pus. He had never passed blood freely and never any gravel. He suffered paroxysmally every two months with intense renal colic on both sides, retracted testicles and vomiting, sometimes culminating almost in collapse, so that on several occasions he had been given up to die. His kidney attacks had been on each side alternately, never on both sides at once. His mother had told him that he passed white deposits in his diaper when he was a baby, and from his birth had been tormented with frequent and painful micturition.

A number of surgeons had examined him and prescribed for him. He had been searched, he told me, several times under ether, and nothing was found. One of these searches nearly cost him his life; it was severe and prolonged, and resulted in (apparently) infiltration about the urethra in front of the scrotum. Extensive abscess formed, and the floor of the urethra in front of the scrotum sloughed away. I found the entire floor of the urethra absent in this region to the extent of over three-quarters of an inch. Through this fistula the patient urinated.

Nothing could be felt in the kidney region by external palpa-

tion on either side. In the purulent urine were a few kidney cells, but no casts. The amount of pus was excessive and the quantity of albumen in the urine considerable. I passed a searcher in my office without an anæsthetic and immediately struck a large stone, which I here show you. It is covered externally with a layer of phosphates; it has not been divided to learn its internal structure; its weight is two ounces and two and a half drachms; its diameters are $2\frac{3}{16} \times 1\frac{3}{4} \times 1\frac{1}{4}$ inches, its circumferences $5\frac{9}{16} \times 4\frac{8}{16}$ inches.

On December 27th, in Bellevue Hospital, assisted by Dr. S. Alexander and the house staff of the Third Surgical Division, the stone was removed by the supra-pubic operation. Twelve ounces of warm water were thrown into the rectal colpeurynter and eight ounces of warm Theirsch's solution into the bladder, after the latter had been thoroughly washed and disinfected. The external incision measured three inches: the vesical incision was about two inches long. Hemorrhage was considerable, the walls of the bladder being very thick and yielding on the cut surface many spiriting arterial points. All of these were closed by inserting under them from the outside of the bladder fine catgut ligatures by means of a small, sharply curved needle—a manœuvre much facilitated by the suspensory threads which had been passed into the bladder on either side of the proposed central incision before the vesical cavity was incised. The peritonæum had been rolled up by the finger in its layer of fat and was not seen. The bladder was freely irrigated and closed throughout with a continuous suture of fine catgut, each insertion of the needle being made to penetrate only half through the muscular coat, and in no instance to enter the cavity of the bladder. The sutures were inserted at a short distance from the cut edge, so that the outside surfaces of the bladder were coapted closely along the whole length of the cut—after the Lambert method. Drainage was secured by a perineal tube inserted in the manner to be described in the present communication. After the bladder had been sutured no fluid escaped through the cut when thrown in through the perineal tube.

The external wound was then thoroughly irrigated with a bichloride solution and closed throughout with deep and superficial heavy catgut sutures, one large drainage tube of rubber being left in near the lower angle of the wound, extending down between the recti muscles into the prevesical space—iodoform gauze and cotton dressing and simple retentive bandage. In forty-eight hours the abdominal wound was reunited, except at the point where the rubber drainage tube entered. On the seventh day the catheter was removed from the perinæum. There had been little discomfort; no chill; very moderate elevation of temperature. On the ninth day there was a leakage of a few

drops of urine through the lower angle of the abdominal wound, due to distention of the bladder. The perineal tube was re-introduced and no more leakage occurred. The drainage tube into the prevesical space had been shortened and made smaller; granulations appeared about it and a few drops of pus could be pressed out daily. One wet bichloride dressing was applied generously over the wound. Within a few hours the patient had a severe chill and a temperature which rapidly ran up above 104° F. The whole abdomen acquired promptly an erysipelatous redness, large blebs formed for a distance of several inches on each side of the united abdominal incision, and a diffuse redness ran down the thighs on both sides and slightly up over the chest. The dressing was changed to a cotton one with abundant dusting with iodoform and bismuth, and the disturbance subsided in three or four days. I believe the complication to have been due to corrosive sublimate poisoning. The attack was certainly not an erysipelatous one, but it retarded recovery. The perineal drainage catheter was left in seventeen days in all. On the twenty-third day the patient was up; on the twenty-sixth day he left the hospital, the entire extent of the abdominal wound having been closed for nearly a week. He left for his home in the West after staying in his rooms in town a few days to recuperate. His urine was nearly clear, his pain had departed, he held his urine three and four hours, and was steadily improving.

Remarks.—Antiseptic precautions were used in all of these cases, the surface of the body being washed with a bichloride of mercury solution, 1 in 2,000, the instruments being in a tray of carbolyzed water, the bladder being cleaned by injection and distended, in one case, with a strong solution of borax in water; in the other two, with Thiersch's solution the wound being irrigated with the latter solution, and, finally, with a bichloride wash.

I think that if drainage can be perfect and the vesical wound sutured, aseptic surgical methods may be consistently applied to the supra-pubic wound, even if a tube is left in the bladder through the perinæum, or through the urethra. I do not, however, see the use of any antiseptic precautions other than cleanliness with warm water, if the bladder wound is to be left open, subject to contact with the urine. In perineal cystotomy I use no other antiseptic measures than hot water and cleanliness, confining my attentions afterwards to attempts at keeping the bladder sweet by borated hot irrigation.

In Case II. I entered the bladder, but left the abdominal wound open. It was simply dusted with iodoform, and lightly

packed with cotton. In the third case, my house-surgeon used one moist bichloride of mercury gauze dressing, during the second week, with a very positively harmful result.

Rectal distention.—I have always used the Guyon bag, on account of its smoother surface and greater ease of introduction, as compared with the Thompson bag. Both hold about a pint. I have not found it necessary, or considered it prudent, to distend this bag beyond ten ounces. In making experiments for another purpose upon the living subject, with a rectal bag distended with air, I have found it not difficult, with moderate distention, to get a show of blood tinging the mucus upon the instrument on its withdrawal, and I do not consider this sign important. I have not noticed it, however, in the foregoing cases where I have used the bag distended with ten ounces of warmed water.

Bladder distention.—I have in each case thrown eleven ounces or less of fluid into the bladder, through a catheter, once silver, twice a soft red rubber catheter. In none of my three cases was the bladder more than faintly visible above the pubis upon this amount of distention. I do not know any certain way to decide how much fluid the bladder will stand without rupture, knowing Pousson's¹ citations of cases in warning where less than seven ounces within the bladder provoked rupture, and Dittel's case² (a boy of five, however), where less than three and a-half ounces ruptured the bladder. To be safe, I think it neither wise nor necessary to wait until the bladder is seen to project in the lower belly. It suffices perfectly well for all operative purposes that the bladder be so distended that it may be percussed out as a resisting body for a short distance above the pubis. It is always easily defined after the knife has opened a way between the recti muscles. Something may be judged of the amount of tension within the bladder by using a comparatively small catheter, so that if the bladder gets a little too full the fluid may be forced out at the meatus alongside the catheter. This occurred in two of my cases, whereupon I ceased injecting and tied a rubber tube about the penis, shutting off the catheter with a compression forceps. In very irritable bladders this expedient does not serve, even under ether, as the fluid always runs out under vesical contraction, as fast as injected, unless kept in by a very large catheter or an encircling band about the penis. In such case the operator must use his own judgment

¹ De deux variétés peu connues de rupture de la vessie Rev. de Chir., 1885. P. 873.

² Wien. Med. Wochenschrift, 1886—42—45.

in deciding how much to inject, but I believe six or seven ounces, is practically always safe in the adult, and a little more is generally well tolerated.

The peritonæum.—The first incision, I believe, is best made boldly, the point of the knife being preferred to the handle, after reaching the muscle, as little tearing as possible being done. If the line between the recti is not struck at once, I think it better to cut through between parallel bundles of fibres than to pull and tear the muscles searching for their dividing line. I have never found it necessary to make any liberating lateral incision along the pubic bone to gain room, but have seen it done by others with apparent advantage.

After passing through the muscles, yellow fat is usually seen beneath, covered by a thin fascia. This thin membrane, down to the fat, may be fearlessly divided, for within the fat, as Guyon has pointed out, always lies the peritonæum.

Bleeding points now being tied, I have always performed Guyon's manœuvre of rolling up the line of yellow fat, peeling it off from the bladder with the pulp of the forefinger. In this way, the peritonæum is rolled upwards, and is not encountered at all. I have never seen it in any of my operations—excepting in one, a case of cancer, in which I attempted to perform epicystotomy, but getting down to this stage of the operation I found that the yellow fat rolled away, and left me a thickened adherent peritonæum, so attached to the bladder that attempts to peel it off were useless. I did not open the bladder at all in this case, but simply drained it through the perinæum; and later, through another abdominal incision, I explored the peritoneal cavity, having in view an extirpation of the posterior wall of the bladder. Finding this impossible on account of rectal adhesions and intestinal perforation, recognized as present before the first operation, I opened the colon in the flank, and sent my patient home after a few weeks, wearing a perineal tube, and having easy intestinal evacuations through an artificial anus in the groin.

Hemorrhage.—When the bladder comes into view, it has on its exposed surface, a few or many (as the case may be) dilated, varicose-looking veins.

I have cut through these without regarding them, in one instance; in the other two, I ligated them all with fine catgut passed just beneath them in two places with a short-curved needle, cutting between. I prefer the latter method. I think it especially desirable not to work down with the finger in the

prevesical space, that badly nourished area of loose connective tissue, where suppuration is prone to occur after injury, and out of which it is not easy to drain the pus effectively.

Retractors.—For inspecting the inside of the bladder, I have found nothing so useful to hold up the sides as long loops of silk passed entirely through the bladder wall on each side of the line of the proposed incision. I make the final puncture boldly into the tense fluctuating bladder from above downwards, with a sharp-pointed curved bistoury, and as the fluid is escaping, insert the narrow, double-curved retractor, which I here show:

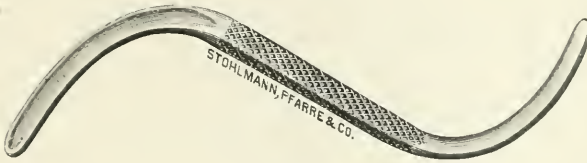


FIG. 1.

By the aid of these contrivances, sometimes assisted by another flat, long, common retractor on either side, the walls of the bladder can be kept up, and every inch of its inside surface inspected with the eye by using an electric surgical light, introduced within the bladder, or employing Trendelenburg's position:¹ that is, having the knees of the patient crooked over the shoulders of a sturdy and tall assistant, while the pelvis is propped up upon a thick, wedge-shaped cushion and pillows, so that the shoulders may be very low, the pelvis high. If now the wound is turned toward a window, by the aid of the loops and retractors, the entire inside of the bladder may be freely inspected, the urethral orifice clearly seen, and the mouths of each ureter. The mouth of a ureter may be sponged dry, and then, by manipulating the kidney region, upon that side the urine may be observed to spirt and trickle from the mouth of the ureter, and may be caught in small quantities in a spoon-shaped scoop. Of the two methods of viewing the inside of the bladder, I prefer the Trendelenburg, if there are plenty of assistants, otherwise, the electric light. If the latter is used, the operator has his patient in a more natural position for operation, *i.e.*, upon his back, flat.

Hemorrhage from the inside of the bladder has not been severe in any of my cases except the first, even after very ex-

¹ Willy Meyer. Über die Nachbehandlung des hohen Steinschnittes, &c. Langenbeck's Archiv., Bd. XXXI., Heft 3.

tensive scraping. A bleeding point can be tied in the bottom of the bladder over a pinch forceps, or, better, by passing beneath it through the tissues a bit of fine catgut by the aid of a small, sharply curved needle held in a long needle-holder. The Paquelin cautery may be easily applied if it seems desirable to do so.

Drainage.—If vesical suture is to be used drainage is of the very highest importance. All sorts of expedients have been resorted to. In some of the earlier operators a perineal opening was uniformly made, not for the purpose of drainage, but to introduce instruments; yet drainage must have been accomplished, more or less, through the opening. I have used in one case a tube passed through the trigone and out through the rectum, but the method is not a good one. This was in one of my first set of cases, and death closed the scene before the drainage could be fairly tested; but I have used the same method with a convolvulus catheter (following McBurney) in several instances when the bladder was not opened above the pubis (or elsewhere, except for the tube, which was passed upon a pointed stylet through the urethra), and I have found it exceedingly difficult to keep the tube in. Drainage by syphonage, with one or two tubes passing out above the pubis, has ardent advocates, notably in France. The objection is that the bladder wound cannot be entirely sewed up, if a tube passes through it. Drainage through a catheter passed by the urethra is a common method. The objection is that it is not safe. No catheter that the ordinary urethra will take is large enough. It is liable to slip out or be forced out by the patient, and almost certain in any case, where tumor has been removed, to become filled with blood-clot, which cannot be readily washed out. It then has to be removed and efforts made to clean the bladder; meantime the wound is in great danger of being flooded with urine.

These considerations have caused many surgeons to prefer to leave the supra-pubic wound open, although the manifest advantages of closing it are obvious, provided union can be counted on through even a greater part of the incision with reasonable certainty. Fistula succeeding the supra-pubic incision is not uncommon, is excessively obstinate and hard to manage, and in more than one instance (from erysipelas, etc.) has been a remote cause of death. I think it is fair to assume that drainage through a large tube from a dependent part of the bladder is a desideratum, and the obvious method of applying this is through the perinæum.

But objection is made here that it is not fair to inflict upon

the patient two serious operations at one time, one above the bone, the other below, which latter, even when done alone is exposed to the possibility of primary or secondary hemorrhage and to other complications. All this objection arises from the fact that it is generally considered necessary to make a considerable opening in the perinæum in order to introduce the tube.

I have devised a method by means of which the tube can be inserted with moderate difficulty, but through the smallest possible wound, and with the certainty, I believe, of avoiding hemorrhage or other complication.

I use a large red rubber catheter, size 30, French, with a large eye near the tip. I pass through the lumen of this catheter a piece of coarse brown twine and bring it out at the eye and then with a needle carry it back through the eye and out through the solid point of the catheter. I then make a large knot upon that part within the catheter and draw the knot down until it catches upon the inside of the catheter at the tip. The outside part of the string is now threaded into the eye of a long silver probe (Fig. 2), which is slightly turned up at its tip. A

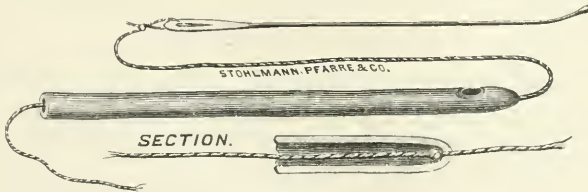


FIG. 2.

steel staff with a broad flat groove is now introduced. The operator passes the forefinger of his left hand, pulp upwards, into the rectum, until he feels the apex of the prostate. Then, with a stiff, straight-pointed bistoury, he transfixes the perinæum as near the wall of the rectum as he feels it safe to go and enters the urethra near the apex of the prostate. By slight forward and backward motion, the knife being held with its edge upwards, the whole line of puncture is enlarged just sufficiently to allow the catheter to pass. Now, the silver probe is inserted carefully along the side of the knife until, by a little manœuvring, it enters the urethra and can be felt in the bladder by a finger introduced through the supra-pubic wound. Now the knife is withdrawn, the probe pushed onwards and drawn out above the pubis, after which it is easy, by aid of the string, to pull the large catheter into the bladder. The string is

now cut and withdrawn and the catheter pulled down until exactly the length desired is within the body. A stitch of silk is passed through the catheter wall at the point where it enters the body as a mark to the nurse that it must be kept introduced to such a depth.

Vesical suture.—In the three cases which I sutured I used catgut and a continuous suture, passing the needle in no instance more than half through the bladder wall, never penetrating the mucous coat, and rolling in the two outside edges so that portions of the outer surface of the bladder were coapted rather than the cut edge.

In one case my union was perfect and no urine ever escaped above the pubis. In the other cases there was trifling leakage, in one case on the ninth, in the other on the fifth day. This leakage only lasted a day or two, and was very insignificant, the perineal tube was kept in until it stopped and prompt recovery without fistula resulted.

After treatment.—I have closed the outside wound with superficial and deep (muscular) sutures inserting always two, sometimes three rubber drainage tubes, the one going behind the pubic symphysis being large, deeply inserted, and the last part of the dressing to be removed. I take out the perineal tube when the abdominal wound is satisfactorily healed, having injected the bladder from two to four times a day through the entire treatment by the perineal tube with a hot Thiersch or other borated solution. I remove the tube for a few minutes on the third day for cleansing, reinserting it at once.

The tube is tied in after the usual manner, and the outside dressings of the abdominal wound are applied according to anti-septic methods.

1 PARK AVENUE, NEW YORK, May, 1887.

ON PRURIGO.

BY

TOM ROBINSON, M.D.,

Physician to St. John's Hospital, London, and Lecturer on Diseases of the Skin.

(Concluded from page 206.)

THE following case came under my observation some years ago, and at the time it made a lasting impression on me. E. B. was aged 68. There was nothing in his previous history which called for comment.

When I saw him first, which was in May, 1879, he was sit-

ting in a chair in his dining-room with his trousers off and a shawl thrown over his legs, so that he might easily scratch his legs, and scratching them he was, most unmercifully. He had also a clothes brush with a long handle, which he used for allaying the irritation.

He complained of a succession of chills, and was extremely irritable, sleepless and distressed by his condition.

I searched most carefully for insects and other causes of itching, but I found none. His skin was a good deal damaged by his nails, but with the exception of a condition which the laity know as goose skin, he had no manifestation of disease. The irritability was always relieved when he was in a hot bath. Lotions and sedatives afforded him but little relief. He got thinner, terribly depressed, and in the September of the same year he became aphasic without loss of consciousness, and, in October, suddenly hemiplegic, and soon died.

Living, as I do, in an ancient part of the town, I frequently see men advanced in years who live in secluded rooms about Gray's Inn or the other Inns, men whose nerve centres are giving way, and I can call to mind several instances where itching of the skin has been the first warning of the beginning of the end.

Eliminating from this group all those in which the cause of the itching was discovered, I have been driven to the conclusion that this special class of cases which comes on suddenly and without any discoverable exciting cause is in reality due to disease in the nerve centre, and my observation would lead me to the conclusion that there is a centre which governs the sensation of the skin. We know there are centres which govern speech, micturition, sight, respiration, etc., and I cannot help believing that these cases are due to disease of a special skin centre. This, I am aware, is purely speculative, but if you will strip a patient with body lice before a class and demonstrate before that class the cause of the itching, it is not difficult to see amongst these several who will commence scratching themselves. This scratching goes on for some time. Again, allusion to itching will set the listener scratching. These are surely examples of pruriginous skins. I suppose many a pruriginous skin is first started by the pleasure which is experienced in having the cutaneous surface gently irritated. We see this especially in the lower animals. Dogs and pigs become docile when you scratch their backs. The trout is taken by tickling in some countries, a fact not generally known, but noticed by Tennyson.

Dean Swift said in his polite conversation that eating and scratching were two things we only had to commence doing and we should prolong. There is probably more significance in the observation than even this sublime wit saw himself.

I should detain the society most too long if I were to even mention the manifold causes of a pruriginous state of the skin, but I must call attention to the terrific itching of the skin which comes on in cases of dropsy of the legs and varicose veins occurring in those who have thick skins. This itching is very commonly the greatest annoyance these patients experience, and is most difficult to subdue.

I will just call attention to the pruriginous state of some skins which is set up by fleas and other irritating animals, and in any case we must search most carefully for these causes. We must also be alive to the kind of garments worn, some rough flannels, some dyes, especially magenta, will cause itching.

Hydrocyanic acid, the balsams and probably the iodides and bromides will cause pruriginous conditions which never assume a definite type of skin disease, or atmospheric conditions, such as east wind, fierce sunlight; also special occupations, such as glass-blowers or smiths, or other employments where the surroundings consist of dust or other irritating matter, will excite a pruriginous condition in those who are predisposed.

I must trespass on your time for a few moments and drag in what is known as pruritus. We apply the word to any condition which itches either around the arms or the vulva, and we very often trip most uncomfortably in applying our lotions or our ointments without making a complete examination.

I am quite prepared to admit that I have under observation at the present time several cases of itching around the arms and spreading forward towards the scrotum, where I can simply discover a glazed and thickened look about the skin, with all the elevations and depressions increased, and with the most troublesome irritation; but in these cases, if our patients are attentive to their symptoms, and if we question them narrowly, we shall be able to find spots which are so distinctly obstructed hair follicles that I cannot doubt the imprisoned hair is again the source of irritation. There are undoubtedly other exciting causes, such as piles, ulcer, polypus, worms, or fissure of the rectum, which set up and keep up the irritation. Sitting occupations again produce this itching in some cases. In others, it is simply an expression of a general eczematous tendency, and for these reasons each case must be treated on its merits.

The pruritus of the vulva, which sometimes mars the happiness of a woman's life, has many sources of origin. It is commonly but an expression of a general dartrous diathesis, locally determined by special anatomical conditions. It seems unusually common at the climacteric period of life, but in some instances it will be found to be associated with a growth in the urethra. One of the most brilliant things I ever saw accomplished was the discovery and excision of a small papilloma of the urethral orifice, which completely cured a long-standing case of vulvar pruritus. I tell this story with some shame, because I had treated in vain this case for many months, and it was not until my patient had passed into other hands that the cause was discovered.

I am aware that the microscopist has discovered a bacillus in cases of pruritus of the vulva, but whether this is the cause or the effect of the condition has still to be determined.

I will now pass on to the treatment of pruriginous skins. By far the most important element in treating any irritable state of the skin, is to use every endeavor to stop the scratching. This is not difficult with those who have work, but with the young, the aged and the idle, or, in other words, with those who have little work and less will, your difficulty is almost insurmountable. It is amongst this portion of the human race that we see the most itching skins. The working man (I use the word in its largest significance) who has an irritable state of skin, itches most after his work is done; he itches most when he has the greatest leisure.

In the first group of cases, where an elephantoid state of the skin has been produced, we can only allay the itching; we are powerless to accomplish more.

In the second group, where the irritation is due to a patch of eczema, the eczema must be treated on general principles. *Id. est.*, if the disease is recent, smear freely with oil, carbolic acid, and oxide of zinc, but if the eczema is old, awake up fresh inflammatory action with an irritant you have confidence in. I know of nothing better than carbolic acid.

The cases where obstructed hair follicles are the cause of the itching will be relieved by prolonged hot bathing and opening of the mouths of the follicles by rubbing with soft soap and flannel.

The lichen prurigo of infants seems to me to be benefited in quite a remarkable manner by hydrocyanic acid given internally, a drop to the year up to three years of age, and a sulphate of soda bath every night.

It has always appeared to me that we have missed a great opportunity in not giving sufficient attention to skin diseases in their relation to other conditions. This remark applies especially to the structures analogous to the skin, that is the mucous and synovial membranes. The subject is a wide one and I can only touch upon it to-night, and draw attention to this common clinical sequence.

A patient has a thick, dirty-looking skin, which skin is pruriginous, that is to say, it is easily irritated, he or she is also bilious, that is, the mucous membrane of the stomach is easily irritated, they get headaches. This passes on through a series of years, then other mucous membranes become catarrhal (I use the word in its largest sense) and later on these patients often drop into joint affections.

I do not wish it to be understood that all pruriginous skins are dense and dark; in the young the reverse is often the case, but the majority of cases which come before us of scratched skins we shall, I think, find in those with such a history as I have tried briefly to sketch. The following is not an uncommon history. I have a patient under observation at the present time who lived in Ceylon for twenty years. She has round patches of eczema about her upper extremities, and, what is curious, these patches undergo the most marked changes which alternate regularly with copious diarrhœa. Of the two evils my patient prefers the diarrhœa.

I had some misgivings when I commenced this paper about the possibility of arranging the matter which was floating about in my brain, in a form which would convey to others any precise opinions on irritable skins, and which might, to a slight extent, clear the ground of some of the obstacles which so surely make the subject of dermatology obscure and uninviting. This misgiving is intensified by a perusal of what I have written. I am conscious that I have advanced but little which every gentleman present knows as well as I do myself. But I have tried to keep in view the causes of what is known as prurigo. Undoubtedly the nomenclature of skin disease can be carried by ingenuity and research to a much further extent than it now is, but is not this dividing and subdividing of classes most confusing?

It is for this reason that I would ask why retain the word *Prurigo*? Clearly it means an itching, but it is more in accordance with common sense if we get rid of those words which simply indicate a symptom, such as *purpuras* and the state we are discussing to-night, and I have ventured to put forward the

belief that we shall always find in all cases of itching skins an exciting cause. It is very different where we have a clinical entity, such as psoriasis or eczema. These words convey at once to our minds a condition which is unique and nothing but confusion would ensue if we were to substitute other words for these which have the sanction of truth and antiquity.

I would sum up my observations by the following postulates, so that I may have the advantage of the large experience of some of the members of the society in assisting me.

I.—There it not such a disease as *prurigo*.

II.—That all cases of itching skins have a recognized and discoverable cause.

III.—That all the group of symptoms which are known as prurigo are the result of scratching, and are simply symptoms.

IV.—All scratched skins which have advanced to an elephantoid state, and which have set up enlargement of lymphatic glands, are beyond the reach of remedies or hope.

V.—That the pruriginous skin of children has its origin in developing hair follicles, which progresses from birth to puberty, when it stops.

VI.—That excessive itching does not occur in those situations where the hair grows luxuriantly.

VII.—That what is known as winter prurigo is due to imprisoned hairs.

VIII.—That an irritable state of the skin is always associated with an irritable state of the mucous and synovial membranes.

ICHTHYOL AND RESORCIN. A CLINICAL STUDY OF THEIR EFFECTS.¹

BY

GEORGE THOMAS JACKSON, M.D.,

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(Concluded from page 220.)

RESORCIN.

LET us now turn to the consideration of the second medication chosen for our evening's study, namely: *Resorcin*, and treat it in the same manner as we did *ichthyol*. The cases here detailed were, with one or two exceptions, all treated by me in Dr. Geo. H. Fox's service at the New York Skin and

¹ Read before the New York Dermatological Society, April 26, 1887.

Cancer Hospital. As a number of the cases reported are examples of very rare forms of skin diseases, I would say that in all doubtful cases I have asked for and obtained Dr. Fox's opinion before entering the diagnosis on my notes. The drug was exhibited in vaseline, unless otherwise indicated, and in strengths running from five to fifty per cent.

I used the drug in nineteen cases, but was able to follow only fifteen of them, as follows: Eczema, 6 cases; epithelioma, 3 cases; tuberculosis cutis, 3 cases; lupus erythematosus, 1 case; lupus vulgaris, 1 case, and psoriasis, 1 case. In some of these cases other plans of treatment had been used before resorting to the resorcin, but in most of them resorcin was the first thing used. Internal treatment was given in only one of these cases; excepting something to relieve constipation or indigestion intercurrently arising in a few of them.

1. ECZEMA. (6 Cases.)

CASE 1.—Bridget H—, M., æt 52. Eczema squamosum chronicum.

May 29, 1886. Resorcin 5 per cent. in ungt. zinc oxide.

June 10th. Much worse. Feet swollen so that she cannot walk. Stop it.

CASE 2.—Jas. McN—, laborer, æt. 39. Eczema squamosum of six years' standing. Varicose veins.

November 23d. Resorcin 12 per cent. in glycerine, applied with camel's hair brush twice a day.

December 2d. Leg itches a great deal more, and is raw and moist. Stop it.

CASE 3.—G. P. K—, clerk, æt. 40. Eczema madidans of genitals and anal region of three years' duration.

November 23, 1886. Resorcin 12 per cent. in glycerine as above.

December 18th. Anal region is somewhat improved. Genitals more raw and inflamed. Stop it.

CASE 4.—Jno. McC—, laborer, æt. 37. Eczema squamosum of crotch, of three months' duration.

April 16, 1886. Resorcin 2 per cent. in collodion.

April 21st. Skin paler and not itchy. Continue treatment.

May 13th. Looking nicely. Continue.

June 12th. Almost well. Continue. Did not see him again.

CASE 5.—Julius H—, school, æt. 14. Eczema squamosum capitis of seven months' duration.

December 4, 1886. Resorcin 3 per cent. in lanolin and olive oil.

December 9th. Great improvement. Continue.

January 6, 1887. Stop resorcin because after first benefit it seems to exert no further influence on the scalp.

CASE 6.—J. C. L—, engineer, æt. 34. Eczema squamosum of six years' duration.

November 29, 1886. Resorcin 12 per cent. in glycerine.

December 23d. Has proved very irritating and caused feet to swell. Stop it.

2. EPITHELIOMA. (3 Cases.)

CASE 7.—Eliza M—, M., *æt.* 49. A case of doubtful diagnosis. Apparently a fungating or warty growth developing upon old psoriatic patch. There is a large elevated patch upon the back which has many of the clinical features of epithelioma. To this pyrogallol and ammoniate of mercury were applied at different times for some weeks without much effect, and on

December 19, 1886. A 5 per cent. ointment of resorcin was ordered.

December 29th. Great improvement. Redness less, fungous granulations reduced. Continue treatment at 20 per cent. strength.

January 7, 1887. Patch on back quite flat and smooth, but a good deal of redness about it in adjacent skin. Stop resorcin and prescribe Lassar's paste with salicylic acid.

March 25th. Patch on back again raised and covered with yellowish crust. Renew resorcin.

April 1st. Doing well, though somewhat sore. Continue treatment.

April 3d. All flattened out. Continue treatment.

April 12th. Doing well.

April 22d. Acute attack of psoriasis over body.

May 13th. Patch small.

May 25th. Patch now smooth; only some redness at former site. After this the patient was not seen.

CASE 8.—Bridget R—, housewife, *æt.* 58. Epithelioma of face, of four years' duration.

August 17, 1886. Resorcin, 50 per cent. ointment. This was continued constantly until

November 4th. Ulcer apparently entirely healed.

December 21st. Middle or old part of ulcer covered with firm cicatrix. Some small ulcerating points about the edge, which are bored out with nitrate of silver.

CASE 9.—John L—, carpenter, *æt.* 44. Epitheliomatous ulcer of seven years' duration.

September 16th. Resorcin, 50 per cent. ointment.

September 18th. Doing well. Continue treatment. He was then lost sight of.

3. TUBERCULOSIS CUTIS, OR SCROFULODERMA. (3 Cases.)

CASE 10.—Ann B—, housewife, *æt.* 66. Chronic ulceration of finger of twenty years' duration.

February 9, 1886. Resorcin 20 per cent. ointment.

February 16th. Better. Continue treatment.

February 23d. Better. Burns a little. Continue.

March 16th. Soreness gone. Ulcer nearly healed. (This was subsequently completely cured with mercurial plaster).

CASE 11.—Mrs. M—, housewife, *æt.* 62. Tuberculosis cutis of back of hand, index and middle finger, for one and one-half years. Skin dark red with tendency to ulceration at various points, and to creep along back of hand.

February 2, 1886. After having used a bichloride of mercury ointment for two months without any benefit, she was given a resorcin ointment of 20 per cent. strength.

February 23d. Skin red and scaly. Continue treatment.

March 23d. Disease spreading down the back of the hand, which is sore and painful. Stop the resorcin and give mercurial plaster.

April 8th. Better in upper part; worse in lower part. Resorcin, 10 per cent. in collodion.

April 15th. Much irritated. Hand swollen. Stop resorcin and use ungt. zinc oxide.

April 20th. Upper part is well. Continue u. z. o.

April 27th. Skin full of purulent matter underneath. Itches a good deal. Resorcin, 5 per cent. in simple ointment.

April 29th. Decidedly better. Inflammatory symptoms ceased. Continue treatment.

August 12th. Now most of the patch is well, and the skin sound.

Incidentally, I would say that the daughter of this patient applied the resorcin-collodion preparation to her corns upon her own responsibility, and cured them. May be in resorcin we have a new corn remedy.

CASE 12.—Nathan W—, æt. 6.

Verrucous scrofulodermata upon left leg, of six months' standing.

After removing crusts with a poultice, on

July 6, 1886, a 10 per cent. ointment of resorcin in agnine was ordered for local use, and arsenic and iron given by the mouth.

September 11th. Majority of patches well. No verrucæ except on lower part of patch on back of leg. Continue treatment.

September 28th. All well excepting one patch over calf, where there is some pustulation. Stop resorcin and order ungt. zinc oxid.

October 7th. All smooth, and only some discoloration. He was not seen again until

March 24, 1887, when he came back with a slight relapse in patch over calf. The other old patches have their location marked by delicate cicatricial tissue, which is dotted like a vaccination scar.

4. LUPUS ERYTHEMATOSUS.

CASE 13.—T. C—, brakeman, æt. 41. Lupus erythematosus of ten years' duration, with nodules with central depression, apparently located about the sebaceous glands of nose.

January 9, 1885. Resorcin 20 per cent. Internally, phosphorus.

January 19th. Great improvement. Nodules have all flattened out. Has never been so well since disease first appeared.

January 30th. Only slight redness and scaling. Stop resorcin and give zinc oxide ointment.

February 2d. No scaling. Slight redness. Order Hydrarg. ammon, 20 grains, in ungt. ox. zinc, one ounce.

March 20th. Has had a few nodules appear since he was last seen, which disappeared promptly under resorcin.

5. LUPUS VULGARIS.

CASE 14.—Eliza G—, M., æt. 36. Lupus non-exedens for thirty-four years.

In this case the bichloride of mercury ointment was used for several months without the least effect.

April 1, 1886. Resorcin, 25 per cent. ointment.

April 27th. Doing well. Patch with more cicatricial tissue through it. Resorcin picks out diseased points and leaves sound and cicatricial parts unaffected.

May 29th. Perpendicular diameter of both ends of patch reduced two mm. Continue treatment.

September 14th. Steady, but slow improvement. Stop resorcin to begin electrolysis on patch.

6. PSORIASIS.

CASE 15.—Jno. H.—, driver, æt. 40. Psoriasis for four years.

May 8, 1886. Resorcin 5 per cent. ointment.

May 11th. Has cleaned up patches, removing the scales. Continue treatment.

August 31st. Up to date has had no further influence, so stop it.

Summary: Resorcin was used in fifteen cases of skin diseases, as follows:

DISEASE.	NUMBER OF CASES.	AV'G TIME OF USING DRUG.	RESULTS AND REMARKS.
Eczema....	6	27 Days	3 Cases aggravated, 2 cases improved, 1 case cured.
Epithelioma	3	4½ Months..	All greatly improved, two of them having been caused to heal up completely, although one had a relapse at edges of patch.
Tuberculosis or Scrofuloderma..	3	3½ Months..	All greatly improved, and one cured, iron and arsenic being used internally.
Lupus Erythem.....	1	2 Months....	Remarkable improvement, causing prompt disappearance of inflammatory symptoms.
Lupus Vulgaris.....	1	5½ Months..	Improved; size of patch lessened.
Psoriasis....	1	3½ Months..	Slight improvement at first; afterwards no effect.

3 Cases made worse.

10 " improved.

2 " cured.

Considering the very intractable nature of most of the cases in which resorcin was used, the results obtained seem to me eminently satisfactory, and I feel justified in making the following

Conclusions: Resorcin is an irritating substance for use in eczema, though at times it may prove very efficient in chronic cases where active stimulation is indicated. It exerts a powerful absorptive effect on new cell infiltrations. It is a useful addition to our list of remedies for the treatment of epitheliomatous lesions where surgical procedures are contra-indicated from any cause.

Society Transactions.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

THE First Annual Meeting was held at Lakewood, N. J., May 17 and 18, 1887.

The Report of Committee of Organization was read and approved. The provisional constitution was regularly amended and adopted. The chief change being the addition of the word "American" before the title of association.

Election of officers resulted as follows:

PRESIDENT—Dr. E. L. Keyes, of New York.

VICE-PRESIDENT—Dr. G. Chismore, of California.

SECRETARY—Dr. R. W. Taylor, of New York.

The following gentlemen were elected members:

Drs. Moses Gunn, Abner Post, G. H. Tilden, F. S. Watson, L. B. Bangs, R. A. Kinlock, H. G. Mudd, E. C. Burnet, C. F. Bevan, E. R. Palmer, R. F. Weir, A. W. Stein, W. M. Mastin, Chas. McBurney.

Dr. Bryson, of St. Louis, was appointed Delegate, and Dr. Mastin, of Mobile, Alternate, to attend the proposed Congress of American Physicians and Surgeons in Washington.

In his opening address the President alluded to the circumstances which led to the formation of this Association of Surgeons interested in Genito-Urinary and Allied subjects. He concluded as follows:

I need not here enter into the question of specialism as distinguished from general medicine and surgery. That distinction is being made for us by the circumstances of the times in which we live. The concentration of labor certainly yields more perfect results than its regular distribution. There is a field ready and those who wish may enter in and work.

Because a man belongs to this Association does not imply that he at all confines his abilities to its peculiar lines of study; but it furnishes to him an arena in which he may develop his ideas and display the work he has done under the keen criticism of minds familiar with the subject matter treated, and capable of still further refining by their discussion the quality of his work and enhancing its value.

The triumphant march of surgery during our professional lifetime has been like a revelation. We constantly now, under the highest sanction of our art, do surgical acts which, but a quarter of a century ago, would have turned us over without mercy to the certain conviction of malpractice at the hands of any intelligent jury. Disease is now hunted out from the recesses of the body at the point of the surgeon's knife. The kidney is attacked from the rear, from the front, on the flank, the urethra is not spared, and the cavity of the bladder is exposed, not alone to the finger-tip and the exploring instrument, but to the eye itself. Operations upon the urethra, the cord, the testis, have, in many instances, been so simplified that a stripling in the surgery of to-day can, in some instances, accomplish results with a rapidity and safety which would have been looked upon as impossible by many of the old-time heroes of surgery.

Syphilology on its side has made such advancements as to yield the palm

to no other line of research. A flowery kingdom full of surprises, new forms and unexpected shapes, its investigation keeps the explorer in a maze of increasing wonderment, until he pauses to ask himself is there anything in the domain of chronic disease which syphilis may not cause, or rather may not simulate? and he is fain to conclude that in the study of chronic disease to know anything well and thoroughly he must first know syphilis.

With so much accomplished and with a portion of the mine worked out the timid spirit may enquire what more is to be done? It is for you, gentlemen, to take a part in answering that question, by devising new methods and simplifying old ones, by studying out the causes of disease, the significance of symptoms, the prophylactic and therapeutic means with which we may combat the common enemy and alleviate the sufferings of mankind. Your committee appointed at the organizing meeting held in New York, October 16, 1886, has finished the task assigned it. Our work is over. The society exists. Its future belongs to you to make of it what you will. I wish you God speed.

DR. GREENOUGH, of Boston, read a paper on

THE COMPARATIVE FREQUENCY OF THE CHANCROID.

The author's records for thirteen years and nine months of his service at the Boston Dispensary—*i. e.*, from July 1, 1873, to March 31, 1887—gave a total of 1,593 cases, of which 391 were chaneroids, 219 true chaneres, 931 doubtful, and 52 herpes progenitalis, making the chaneroid stand in proportion to other lesions in the ratio of $\frac{1}{4}$, or 1 to 3. These records were unsatisfactory, inasmuch as they showed merely the diagnosis made at the time of the patient's first visit. His private case-books showed that, of the last 100 cases seen, 10 were chaneroids, 63 true chaneres, 13 doubtful, and 14 herpes progenitalis—a ratio of 1 to 10. Although much smaller numerically, these were much more reliable, as the diagnosis was made after having the patients under continued observation. Both sets of statistics showed a diminution in the frequency of the chaneroid. This he thought was in part due to a change in type of the disease. Herpes progenitalis, not having been recognized by the earlier syphilographers, had undoubtedly often been taken for chaneroid, as had probably also a not uncommon inflammation of a sebaceous follicle on the shaft of the penis; and the treatment of either of these lesions by destructive canterization, which had formerly been the general practice, would make a very good imitation of a chaneroid. He thought that at present a virulent bubo was not more frequently seen in connection with a chaneroid than with a true chanere, which he considered somewhat due to the fact that this lesion was not so frequently imitated by caustics; and he also ascribed the greater rarity of the chaneroid to the fact that it was no longer manufactured by cauterizing every venereal sore that was not a typical true chanere.

DR. F. R. STURGIS.—According to my experience in Charity Hospital, chaneroids have certainly diminished in frequency within the last few years, but they have varied in frequency from year to year, according to the amount of alcoholics used and the amount of clandestine prostitution which has taken place. Another noticeable fact at that hospital seemed to be the difference in the class of women brought there for venereal treatment. It seemed that during the past ten years, as compared with the previous ten years, the patients were composed more of young girls. They averaged perhaps twenty

years of age, while in the previous ten years they averaged thirty or thirty-five years.

I strongly believe that the early, as well as the late lesions of syphilis are capable of being irritated into a secretion of purulent matter, capable of producing local contamination, particularly in these persons who have had syphilis or are under the syphilitic diathesis. A person who has never had syphilis may have a simple sore which is capable of being irritated to secrete inoculable pus. If that is true, the scarcity of chancreoid may be accounted for by the greater care and attention to cleanliness and hygienic measures in recent years.

As regards the question whether the cauterization which has been practiced has been to some extent the cause of chancreoids, I believe there may be some ground for it. But if we admit that to be a fact I do not see how we can avoid the next step, that is, admit that the virulence of the so-called chancreoid depends upon an inflammatory action, and not upon any inherent peculiarity in the pus or character of the lesion itself. In other words, the inoculable material may be obtained from any sort of pus provided the sore from which the pus is obtained be irritated to the point at which it is capable of producing autoinoculation, and that the tissues to which the pus is conveyed have a certain capacity for inoculation.

According to the statistics which I collected some years ago from Charity Hospital, the New York and other dispensaries, the proportion of suppurating buboes was only about one in four. So my impression is that in New York the proportion of suppurating buboes is very small.

DR. R. W. TAYLOR.—I agree with Dr. Greenough and Dr. Sturgis with reference to the comparative rarity of the chancreoid. In private practice I think there are about three chancreoids to one hard chancre. But it must be remembered that under the chancreoid there has been described a multitude of conditions, as I shall try to prove at some future day.

According to my observation there are two forms of *ulcus elevatum*, a syphilitic *ulcus elevatum* and a chancreoid *ulcus elevatum*. In some instances they resemble each other very much indeed; in others they do not.

DR. J. N. HYDE.—I am entirely inclined to agree as to the statistical question with Dr. Greenough.

With regard to making a positive diagnosis, I know it can be made in some cases at once, but I think we ought to come to this conclusion, that the diagnosis of chancreoid is really a matter of months. We ought to get it out of the minds of physicians that the expert can look upon a lesion on any portion of a man's body and then and there decide positively the grave question of whether or not it is syphilitic.

DR. P. A. MORROW.—I have always been accustomed to regard chancre as a much more aristocratic disease than chancreoid; a sort of sign or seal of gentility on the part of the bearer.

I took occasion some time ago to institute inquiry into the relative frequency of chancre and chancreoid in Charity Hospital. The clerk gave me a record embracing a period of four years of the number of cases diagnosed as chancreoid and the number of cases diagnosed as chancre; and also the total number of cases of venereal disease. I am very sorry that I have not that paper at my service at the present moment. I have a very distinct recollection that there were certainly eight cases of chancreoid to every case of chancre. In my dispensary practice, extending over a number of years, I think the proportion is not nearly so large—possibly three chancreoids to one chancre. In my private practice it is extremely rare for me to treat a chancreoid. I think the experience of many specialists in large cities is that the number of chancreoids seen in private practice in proportion to the number of chancres is very small indeed.

There are always certain elements of error in statistics as to the relative frequency of chancre and chancreoid, which cannot by any possibility be eliminated.

As regards the differential diagnosis between chancre and chancreoid, I think there are many cases in which it is simply impossible to differentiate between the specific or non-specific nature of the venereal sore, except by time.

As to the relative frequency of virulent buboes, I have no statistics. According to my observation I am disposed to believe that they occur more frequently than Dr. Sturgis's remarks upon that point would seem to indicate. It has always been a very difficult question with me to decide what relation the development of the virulent bubo bore to the specific or non-specific nature of chancreoid. We know that in a large proportion of cases virulent buboes do not develop in connection with chancreoids. I think this has really a very important bearing upon the determination of the point, whether the chancreoid is due to a special virus or is simply an inflammatory product.

DR. ROCKWELL.—In my service at St. Mary's Hospital, Brooklyn, I am quite positive that, excepting cases which were sufficiently advanced to end in an ulcerating bubo within a few days, there has not resulted a single case of bubo, either on the male or female side. The treatment has been largely that suggested by the reader of the paper—simple, mild treatment, with no cauterization.

DR. F. N. OTIS.—Regarding the tendency to give up the old plan of treatment by cauterization, which the author thinks is manifest, I hold that immediate destruction of the chancreoid is desirable in every case excepting where the extent of the inflammatory condition, or other local state, contraindicates it. When a chancreoid makes its appearance a drop of nitric acid is sufficient to destroy it. I have seen many cases in which there did not seem to be very much disposition to active progress in which I have pursued a mild course of treatment. But when chancreoidal ulceration is in active progress, I have found nothing which so promptly stops its progress as cauterization. The sooner the chancreoidal action is stopped the less the danger of purulent bubo. I do not think that inflammatory trouble is ever set up by a local application of the cautery. We see cases of simple adenitis caused by irritation; then we see cases of virulent adenitis occurring from chancreoid. In the first case, if the sore goes on to suppuration, which it rarely does, we have simple pus; in the other we have inoculable pus, and suppuration here is almost inevitable.

I have found the chancreoid frequent as compared with the initial lesion. I have not found that the most refined of my patients always avoid getting a chancreoid. There is very great difficulty often in determining whether a sore which has the appearance of a chancreoid is a true chancreoid or not. I do not think too much can be said in favor of postponing a positive diagnosis several weeks, or perhaps several months.

The observations upon the *ulcus elevatum* have interested me very much. I think with Dr. Taylor that there are two varieties. The one form called the chancreoidal is simply the result of a secretion of a very low irritative power. It is rather a proliferation of the mucous follicles of that part. It is not destructive, but it is in a very low degree contagious. It resembles a mucous patch very much indeed when situated upon a mucous surface. I have looked upon those associated with syphilis as being mucous patches, irritated, as we know they are, and taking somewhat the type of mucous tubercles at that point.

THE PRESIDENT.—Regarding the remarks which have been made on statistics, giving the relative frequency of chancre and chancreoid, I agree.

The virulence of the chancreoid is not under discussion; but as it has been referred to incidentally, I will say that I am a firm believer in such virulence.

I would like to say in connection with Dr. Otis's remarks that I approve entirely of cauterization of lesions which are known to be virulent. The

time to make cauterization is within the first ten days. If you cauterize after that you will not materially lessen the duration of the sore, nor will you prevent it from spreading to adjacent tissues. Many years ago I circumcised a man at Charity Hospital, and cleansed and disinfected a little sore at the end of the penis where the lymphatics are most active, that is, near the frenum. All the rest of the sore healed by first intention, but at this point a little tubercle or chaneroid appeared. I believe there was some virulent material in the lymphatic system which poisoned the gland at that point. That is pure theory, but I believe that if that point had been cauterized the sore would have been cured. In my early practice I was in the habit of inoculating sores, and in no instance do I remember of having failed to cure such an inoculated sore with a drop of nitric acid. I do not believe the probability of the development of a virulent bubo will be enhanced by burning the sore; on the contrary, I think that the virulence of the sore being destroyed by such cauterization, the probabilities of a bubo are lessened.

DR. GREENOUGH.—I appreciate what Dr. Taylor and Dr. Otis have said concerning the *ulcus elevatum*. I have seen these little round elevations with their ulcerated surfaces coming in contact with one another, suggesting that they are the result of auto-inoculation, yet they were followed by secondary symptoms. In other words they seemed very much like what Diday described as mixed chancre.

I have only to say that my ideas regarding treatment have been followed out for some years, with a good deal of thought, observation and experiment, and I have seen no reason to change them. I am perfectly well aware that if you see a chaneroid at a very early stage and drop nitric acid on it it will be destroyed. But I do think that in a great many cases if a drop of nitric acid had not been used, a simple lesion would not have developed into a typical chaneroid. I will not say that irritation will produce a virulent bubo, but I use bubo in this connection in the sense of a suppurating adenitis. I have certainly seen several cases in which the act of cauterization of a sore on the prepuce was followed by enlargement, and in some cases by redness, inflammation and breaking down. That, of course, may have been simply sympathetic enlargement which, with perhaps other circumstances combined, caused it to go on to suppuration.

DR. KEYES, of New York, read a paper upon

SUPRA-PUBIC CYSTOTOMY.¹

DR. A. T. CABOT.—There are one or two points in this paper which I would like to speak of. In the first place, there is the question of choice of operations in children. Dr. Keegan's results have certainly been remarkable, fifty-eight cases with only one death after litholapaxy. But it is to be remembered that Dr. Fayrer, also practicing in India, has had 143 cases of lateral lithotomies in children without a single death. It is a question whether Dr. Keegan's results can be substantiated by the work of others, or whether they are only exceptional. If they are exceptional they should be compared with such results as Dr. Fayrer's, which are better.

With regard to the treatment of the wound, when left in contact with the urine, I think that it is extremely important to use every antiseptic precaution possible, not alone to protect the wound against putrefaction, but also against erysipelas, pyæmia, septicæmia. None of the agents likely to cause those conditions exist within the bladder, but they are likely to be introduced from without. Where an incision has to be made and the urine being foul has to traverse the wound for sometime after the operation, it is still important to use antiseptic methods to protect the wound from external infection.

¹ See page 242.

My experience with the supra-pubic operation has been limited to three cases. In the first case I used the old sonde à dard. The bladder, being empty, retracted deeply into the pelvis and was difficult to reach. Behind was a sarcomatous mass difficult to remove. Last year I had a case of stone in the bladder of large size, somewhat larger than the stone presented by Dr. Keyes. There was a urethral stricture which I first divided, and then felt the calculus. The procedure adopted was very like that described by Dr. Keyes. The peritoneum caused difficulty, for the patient was breathing hard under the ether, and with every deep inspiration the bowel would enter the fold of the peritoneum and press it under the pubis. But by hooking the peritoneum up with the finger I was able to puncture the bladder, and with the forefinger as a guide the forceps were introduced and the stone withdrawn. Perineal drainage was not provided for, but the bladder was kept perfectly empty by a syphonic action through a rubber tube passing over the bed into a bottle. The case progressed well; no fistula was left.

With regard to the amount of distension of the bladder by the injecting fluid, I find it to be well indicated by a piece of rubber tubing placed between the catheter and the syringe.

Suture of the bladder is a method which, I will confess, I had not the boldness to try. I preferred the method of drainage over the pubis, as it appeared to me the safer one, and as avoiding the possibility of urinary infiltration above the pubes.

DR. ROCKWELL, of Brooklyn.—Mr. President: There is at present in St. Mary's Hospital a case operated upon by Dr. Fowler, about ten days ago, by supra-pubic cystotomy. A sarcomatous mass, about half the size of that shown by Dr. Keyes, was removed with the greatest ease. Some difficulty was experienced with the peritoneum which tended to protrude into the operator's way. Supra-pubic drainage was employed, as Dr. Cabot has described. But in that case very serious results followed the coming away of some of the antiseptic silk, allowing of urine entering the prevesical space and interfering with rapid recovery. There probably will be a fistula. I think if perineal drainage had been provided for this accident might have been avoided.

DR. J. P. BRYSON, of St. Louis.—As regards the question of choice of operations, and the reasons given for choosing the supra-pubic in preference to the perineal operation, I entirely agree with the writer of the paper. The question, it has seemed to me, admits of two divisions: first, as regards drainage; second, as regards the amount of bruising which is permissible, either in the removal of a tumor, calculus, or other foreign body. Special stress has always been laid upon the matter of bruising the parts during removal of the foreign body, and I have been led to believe that very little more bruising will be tolerated by supra-pubic cystotomy than can be tolerated by perineal incision. I have not been favorably impressed with the greater facility of inspecting the bladder by the supra-pubic operation.

The question which has been most prominent in my mind concerns drainage. On this point the suggestions of Dr. Keyes are most excellent, especially with regard to the small opening necessary in reaching the viscus. Good drainage must be obtained, if a fair degree of success is to follow the supra-pubic operation.

DR. F. N. OTIS.—There cannot be any question about the superior facilities for examining the bladder offered by supra-pubic section, and undoubtedly the operation will find a permanent place in surgery. At the same time we should not forget that very large stones may be removed with considerable prospect of safety as well as of success through the perinæum. I have seen the supra-pubic operation performed for the removal of stone which could very readily have been removed through an incision in the perinæum. Of course, if it were a hard stone of great size the question of supra-pubic operation would be readily decided.

The next paper was upon

HYSTERECTOMY FOR PYELITIS WITH OBSTRUCTION,

by Dr. A. T. Cabot, of Boston.

The author gave the history of a case of pyelitis in which the symptoms of obstruction of the uterus came on late in the history of the fibroid. The tumor was low in the pelvis and about the size of a child's head. A second tumor about the size of an orange was connected with one ovary. Later the condition of the urine and the character of micturition, pain, etc., pointed to cystitis from pressure. Two weeks later the symptoms were those of probable suppuration in one or both tumors. The smaller abdominal tumor was removed, after which micturition was less frequent. But the appearance of pus in the urine and other symptoms pointed to pyelitis, the condition of the kidney being considered due to pressure of the pelvic tumor. At an operation for its removal it was with difficulty that it could be pushed up into the abdominal cavity, so tightly was it wedged in the pelvis. The uterus was removed with the tumor, only a part of the cervix being left. The patient rapidly regained strength, and wished to return to work. The urine had become almost clear.

The Secretary read a paper by Dr. George Chismore, of San Francisco, entitled:

SOME CASES OF PYELITIS, IN WHICH FREQUENT AND PAINFUL MICTURITION WAS THE CHIEF SYMPTOM.¹

Dr. J. H. BRINTON, of Philadelphia, read a paper on

HORNY GROWTH OF THE PENIS, WITH EXHIBITION OF A REMARKABLE CASE.

He exhibited a specimen from a man on whose penis a horn had existed more than four years, having started from a wart. The wart had itched occasionally, and the patient had scratched it for this reason. Gradually it turned into horny substance. It caused no trouble, except mechanical interference with coition. The horn sprang from the base of the glans, at the coronary border, and was attached to both the glans and prepuce; it was one and seven-eighths inches long, one and three-eighths inches in circumference; it was curved forward. A peculiar feature in this particular case was the fact that the horny plate surrounding the meatus almost occluded the meatus, so that the urine passed only in drops. The urethra behind the horny plate was not contracted. The horn was cut off, and the man left the hospital after about three weeks.

Dr. BRYSON.—I think it is a mistake to say that irritation causes these horny growths, for there are hundreds of cases in which irritation accompanying phimosis, etc., exists without horny growths developing. They are not uncommon about the lip.

Dr. R. W. TAYLOR.—I think I have read all published cases of horny growths of the penis, and so far as I remember, Dr. Brinton's is unique with regard to the band attached to it.

A paper on

THE CHOICE OF OPERATION FOR THE REMOVAL OF VESICAL CALCULUS IN CASES COMPLICATED BY PROSTATIC OBSTRUCTION²

was then presented by Dr. J. P. BRYSON, of St. Louis.

Dr. F. N. OTIS.—My own impression has been that when an operation

^{1 2} Will be published in a subsequent number of this Journal.

is called for, and there is complicating prostatic trouble, the latter condition has not been sufficiently considered in deciding upon the method of procedure. In such cases an operation for the removal of the stone which will enable the operator to make an incision into the vesical neck is of very great service to the patient subsequently.

THE PRESIDENT.—How far down on the floor of the prostate did Dr. Bryson cut?

DR. BRYSON.—My aim was to cut to the apex of the prostate and then do as much dilating as possible with the finger, and not cut into the prostate. The tube was kept in ten to fourteen days, or as long as the patient would stand it.

DR. A. T. CABOT.—Regarding the difficulty of evacuating fragments, I think there is another besides that of getting the tube to the bas-fond, namely, the likelihood of fragments being retained in side pockets from which they are difficult to dislodge. I frequently find, after pumping out the bladder, the water coming away clear. That when the current happens to be directed into another channel it brings away a shower of fragments, showing that they had been retained in some pocket separate from the others. It is an advantage to raise the hips and throw the stone further back into the bladder, displacing it from the bas-fond, where it can be reached by the lithotrite.

By carefully pumping out the fragments after the crushing operation, and then placing the patient under proper treatment by irrigation, I have been enabled to bring about a very comfortable state.

As to the question of the condition of the prostate being the cause of the stone, I think it is very interesting. I have looked over the records of the operations for stone which I have performed, and I found that considerably over half were done behind the enlarged prostate. Of sixteen cases in which the stone occurred behind the enlarged prostate and litholapaxy was performed, in five there was uric acid stone, in eleven phosphatic. That is to say, in eleven cases the stone formed probably in consequence of a cystitis resulting from an enlarged prostate.

As to the question of the reduction of the size of the prostate after a perineal operation, it would be desirable to know how much the diminution in size is due to reduced hypertrophy and how much to disappearance of inflammatory swelling. Dr. Hammond reported some instructive cases about 1881, cases in which he drove the trocar directly through the prostate into the bladder, and left the canula in for some time, or until the urine began to pass by the natural channel, when the canula was taken out. It was then found that the prostate was very much diminished in size compared with its previous condition. The operation, however, had not been devised to reduce the obstruction, but simply to drain the bladder.

THE PRESIDENT.—It seems to me that this paper is exceedingly suggestive, but at the same time not conclusive. I rather protest against two inferences, or against one at least, namely, that prostatic enlargement makes very much difference in getting out the last fragment. The majority of my cases, certainly three-fourths of them, have been in persons with enlarged prostate, and I do not regard that as a condition which should prevent removal of all the fragments.

(The President then exhibited a form of Mercier instrument for removal of stone from the bladder, which he regarded as superior to any other.)

The other protest which I would make is, that it is hardly fair to make a stone of moderate size an excuse for the cutting operation in an old man. Dr. Bryson's statistics are admirable—one hundred per cent. recoveries. But this is not the usual experience. As a matter of fact, it is quite a serious thing to cut an old man's prostate for removal of stone; therefore, it seems to me like begging the question to advocate the cutting operation simply for a small stone when that stone can be equally well removed by litholapaxy,

which is a much less dangerous operation. Two or three per cent., or five per cent. at the outside, is the mortality from litholapaxy at that age, while it is more than five per cent. from the cutting operation. Why not, then, have the stone removed by litholapaxy, and if the patient does not then do well, attack the bladder as an independent factor in the production of the symptoms?

The question of cutting into the bladder through the perinæum, and removing a stone when there is a condition of the prostate itself which makes such an operation justifiable, is another thing. I have operated in two instances of that kind. In one, the patient had not passed a drop of urine, except through a catheter, for four years. He had a large prostate, but an instrument would pass into the bladder with perfect ease. There was a ball-valve at the bladder, which I cut through and removed three phosphatic stones. The patient afterward urinated without the use of the catheter. In this case the perineal operation was chosen, not because the crusher could not be introduced, but because the man had been unable to pass his urine without a catheter for four years.

I have generally endeavored to lower the level of the prostate somewhat by cutting upon its floor in the median line and introducing a large tube. I think patients get better after this procedure.

DR. F. N. OTIS.—I agree entirely with the remarks of Dr. Keyes on the possibility of removal of stone by the crushing operation when there is enlarged prostate; the possibility of removing even the last fragment. My remarks were intended to apply only to those cases in which there was sufficient difficulty with the prostate itself to justify cutting it, and then introducing a large tube to remain as long as the patient will submit to it.

DR. BRYSON.—I took occasion to say in my paper that litholapaxy was the operation of choice. I have always chosen litholapaxy where it was applicable, preferring not to cut in old men. In none of the four cases which I have reported was the cutting operation the operation of choice, but rather of necessity. I have found it difficult to measure the diameter of the prostate and determine the condition of the vesical inlet by rectal examination, even with the catheter introduced into the bladder.

As to what amount of the prostatic enlargement is due to inflammatory congestions rather than hypertrophic changes, my observation has led me to believe that it is inflammatory enlargement; and that the reduction in size was due to diminution of the inflammatory products rather than to diminution of hypertrophic tissue. At the same time it seemed there might be along with subsidence of inflammatory infiltration some atrophic change.

I have little doubt that in my cases the prostate was cut somewhat along the floor, and it is barely possible that in stretching the wound, pressing the lobes laterally, the prostate may have been somewhat torn. At any rate the sensation given the finger was that the floor of the wound had been lowered and that the anterior portion of the prostate had been severed by dilatation with the finger or else cut.

DR. P. A. MORROW, of New York, read a paper on

IDIOSYNCRASY AS AFFECTING THE SPECIFIC TREATMENT OF SYPHILIS.¹

DR. F. N. OTIS.—This is a large subject to treat of in a single evening. I am quite in accord with Dr. Morrow's views, that certain patients have idiosyncrasies with regard to these medicines.

I think we can often overcome an apparent idiosyncrasy by careful management of the patient and of the drug. I am quite certain there are some cases which will not bear any amount of the two drugs referred to in the paper, but such cases are exceedingly rare. When they occur we must resort to other measures for the treatment of the disease. It is safe to teach that, as a

¹ Will be published in a subsequent number of this Journal.

rule, syphilis should be treated by mercury, iodide of potassium, but of course we must admit that all patients are not alike responsive to these drugs; that the physician must feel his way in their use, and be directed in his course by the effects; that when the point has been reached where the general system is being affected we must stop it. The same is true with regard to iodide of potassium.

DR. F. R. STURGIS.—There is no doubt but what there are certain cases such as Dr. Morrow has mentioned, in which it is impossible to give either mercury or the iodide of potassium, notably the latter. But I believe that many of the cases which pass as idiosyncratic are so because of improper administration of the drug, or of some article of diet which produces a toxical effect. It has been noticed in Charity Hospital that nearly all patients who have been taking mercury show more or less of its peculiar effects on Fridays because on that day they receive salt fish diet. In cutting off the salt the bad effects of the mercury disappear. So with regard to the peculiar effects of iodide of potassium, producing gastritis, etc. I think it is often due to the fact that the drug has not been properly and sufficiently diluted. If the iodide of potassium is not sufficiently diluted and is taken on an empty, or partially empty, stomach it will almost surely disagree. But there are undoubtedly cases in which iodide of potassium does produce exanthemata, bullous eruptions, etc., and in such cases attempts at medication by this means must be abandoned. The rectal use of the drug has not in my hands been successful.

DR. J. N. HYDE.—The author has dwelt largely on the cutaneous side of the exceptions, but there are idiosyncrasies in other respects. I have lately had a gentleman consult me on account of syphilitic periostitis. He said he could not take iodide of potassium, not on account of any cutaneous exanthemata, but because of a peculiar inflammation of the bowels. I tested him, giving him small doses. He returned with very severe distension of the abdomen, with a great deal of pain and soreness which subsided very rapidly on discontinuing the drug. I have recently seen one of those unfortunate cases of endarteritis obliterans in which there was most excruciating pain in the back produced by the action of this drug. The urine exhibited traces of the drug when administered in the smallest doses almost immediately after it had been swallowed.

DR. GREENOUGH.—I should thoroughly agree with Dr. Morrow in not feeling inclined to push either of these drugs when there was evidence of their toxic effect. I certainly should not want to continue the iodide in a case in which there were bullous, pustular or purpuric eruptions due to its action. I remember Hebra presenting a case, showing extreme sensibility to mercury, that of a Russian princess who was salivated by one application to a mucous patch of the acid nitrate of mercury. The past six months I have had occasion to use a pill of the bichloride of mercury in doses of one-fifteenth of a grain. Several patients have complained that it produces vomiting within a few minutes after it is taken. I have tested several by giving them the drug without their knowing it, but the effect has been the same. There is not a very large number of patients who have shown this peculiarity, otherwise I should suppose there was something wrong with the medicine.

THE PRESIDENT.—I have but two things to say: First, to express my entire belief in the existence of an idiosyncrasy, which I have seen as marked as in any of the cases related by Dr. Morrow. I also believe that under those circumstances these drugs do not do any good. They have their parallel, for instance, in codliver oil. If the administration of a few drops of codliver oil causes nausea and diarrhoea in phthisis, it will not only not do good, but it may do harm in preventing the digestion of foods.

DR. P. A. MORROW.—I have simply to reiterate my faith in the remarkable therapeutic efficacy of mercury and iodide of potassium in a large majority of

cases of syphilis, but I believe cases of idiosyncratic intolerance of these drugs occur much more frequently than is commonly recognized. There seems to be a generally growing sentiment among observers in this country, and especially in Europe, to regard the iodide of potassium as a possibly dangerous drug in many cases of syphilis. At a recent discussion before the London Medical Society, on the subject of the treatment of syphilis, there was a most emphatic general expression of opinion to the effect that, under certain conditions of the system, iodide of potassium was expressly contraindicated, and that it was not a safe thing to overwhelm the system with large doses of the iodide, as taught by many distinguished authorities.

The next paper was from DR. R. W. TAYLOR, of New York.

OBSERVATIONS ON THE USE OF OIL OF WINTERGREEN IN THE TREATMENT OF GONORRHOEAL RHEUMATISM,

in which he detailed the histories of about twenty cases of gonorrhœal rheumatism occurring in Charity Hospital the past year, in which he had given the oil of wintergreen a thorough trial. In about nine of the cases the disease was of that chronic kind, in old or neglected subjects, in whom no treatment could prove of much benefit. In the others the benefit was marked, and most of them after some weeks recovered entirely. The drug was administered in capsules in pretty large doses, varying according to the circumstances. The urethral secretion also became bland under the action of the drug, and disappeared. Other remedies had in most cases been tried with little or no effect.

DR. J. N. HYDE.—I would ask Dr. Taylor whether in all of his cases there was synovial complication, or whether some of them were of the nature of reflex neuralgias, as we sometimes see them.

DR. TAYLOR.—My impression is there were synovial complications in the form of congestion and not of structural change. But the tendency of this disease, as you know, is for the congestion to go on to fibroplastic deposit. And I think the line should be drawn as to the usefulness of this remedy at those early cases, before this structural and degenerative change has taken place.

I would not have it go forth that oil of wintergreen has an absolute antilenorrhagic effect; but the evidence of the cases presented point in that direction. It certainly has this effect, that it will ease the pain of these patients at once when pushed far enough, and it will not be attended by that burning, unpleasant sensation in the urethra and perineum which patients complain of after taking iodide of potassium and salicylic acid.

A paper by DR. ALGERNON S. GARNETT, of Arkansas, was read by the Secretary, entitled

A FEW PRACTICAL OBSERVATIONS ON THE TREATMENT OF LATE NEOPLASMS OF SYPHILIS.¹

The next paper was entitled

TEMPORARY OVERSTRAIN OF THE BLADDER PRODUCING CHRONIC RETENTION OF URINE,

by Dr. F. N. OTIS, of New York. He called special attention to that form recognized as occasionally resulting from sudden overstrain by reason even of a single attack of retention, particularly when it occurred independently of any organic obstruction, but probably as a result of reflex irritation caused by a contracted meatus urinarius or a urethral stricture of large caliber. The

¹ Will be published in a subsequent number of this Journal.

most salient points of the paper were: 1. The importance of recognizing the influence of even slight urethral stricture in producing sudden retention of urine. 2. The importance of early recognition and relief of such retention by catheter, and in this connection the author advised against a too rapid emptying of the bladder, and stated that by a gradual withdrawal of the urine the dangers of syncope, hemorrhage, and cystitis were to a great extent avoided. 3. The fact that a localized atony of the bladder might be present in sufficient degree to prevent voluntary urination while the contractile power of the superior portion of the organ remained practically undiminished. 4. Failure to restore the urinary function in such cases by other measures suggested a possible cure, even in long-standing cases, by incision of the vesical neck.

DR. BRYSON.—About ten years ago I saw a man at midnight who had not passed his urine since eleven o'clock in the morning. He had no apparent difficulty with the bladder or urethra, but had suddenly become unable to pass his water. I introduced a catheter with very little difficulty and withdrew a large quantity of urine. The sound was introduced the next day. He had no further trouble. The question suggested itself, as it did while Dr. Otis was reading his paper, whether the passage of the sound, when that can be done, will not in many of these cases overcome the difficulty. I have seen quite a number of cases, as you all have, where overstrain has resulted from temporary atony.

DR. HYDE.—Some years ago I saw a man aged seventy who had not passed any water for sixteen hours. I introduced a catheter and drew off quite a large amount of urine. He was under my observation for five years, and at the end of that time died of an intercurrent trouble. He had to use the catheter for some time after the temporary overstrain, and at night during the remainder of his life. I examined him a number of times under anæsthetic, alone and with expert surgeons, and we were unable to detect any abnormal condition. The prostrate and urethra were normal.

DR. CABOT.—I should entirely agree in the suggestion that in these cases of retention of urine a sound be passed into the bladder. In ordinary cases of spasmodic contraction of the sphincter I pass the largest sound the urethra will admit, perhaps cutting the meatus which Dr. Otis says is often the cause of the spasm. I would ask Dr. Otis whether he does not think cutting the anterior strictures, if the large sound will not pass in these cases, and then passing the large sound through the compressor urethrae would not be likely to give relief.

DR. OTIS.—Undoubtedly a large proportion of cases would be relieved by passing the sound.

DR. MORROW.—I would ask Dr. Otis whether it is always necessary to divide the meatus. I have known patients to experience immediate relief from irritability of the bladder, from which they had been suffering more or less for sometime, simply by passing a large sound, larger than the natural orifice, and overdistending it, and in doing so causing the patient some pain. The sound is not passed down into the bladder. I would refer to certain cases of retention of urine occurring in connection with ataxic symptoms. Many of these cases feel no discomfort whatever from great distention of the bladder. I do not believe that there is any relief for these ataxic cases by operative procedure. Cutting the urethra does no good whatever.

DR. OTIS.—A case was under my care some time ago, that of a man who passed his urine very frequently, requiring five or six towels during the night. I sought the advice of Dr. Seguin, who pronounced the case a perfectly typical one of posterior spinal sclerosis, and expressed the opinion that not much could be done for the patient. He gave a very unpleasant prognosis. I found a contracted orifice, and thinking it might be the cause of some irri-

tation I divided it. That night the patient required but one towel, and subsequently, for nearly two years, he had no trouble whatever with urination.

DR. BRYSON.—I have seen a number of cases in which the vesical atony was evidently due to ataxic symptoms, and division of the meatus had no influence whatever.

THE PRESIDENT.—I have never seen but temporary relief in such cases from division of the meatus. But I have also seen cases get well without doing anything.

DR. J. N. HYDE, of Chicago, read a paper entitled

EARLY SYPHILITIC EPIDIDYMITIS.

The following propositions, he thought, rested on fairly sound clinical grounds: 1. A male patient may suffer from blennorrhagic epididymitis on one side, subsequently contract syphilis, yet escape syphilitic involvement of the epididymis. 2. A male patient may suffer from blennorrhagic epididymitis, involving first one organ, then the other, finally acquire syphilis, and escape syphilitic epididymitis. 3. A male patient may suffer from blennorrhagic epididymitis of one or both organs, become so irritable as to exhibit by inflammatory accidents sympathy with successive blennorrhagic attacks, yet throughout a final syphilis betray no sensitiveness to the last-named disease. 4. A male patient affected at the same time with syphilis and blennorrhœa may suffer from an epididymitis, evidently a complication of the last mentioned disease—namely, blennorrhœa—and yet escape syphilitic involvement of the organ. 5. A male patient may suffer from tuberculosis, subsequently incur syphilis, yet the epididymis escape involvement. 6. A male patient who has suffered from repeated attacks of blennorrhœa, and that lately, may exhibit the typical form of early syphilitic epididymitis.

DR. STURGIS.—I would be inclined to look upon cases in which there was pain as either traumatic or occurring in persons in whom there was perhaps an old urethral discharge.

DR. F. N. OTIS.—I do not remember to have ever seen an undoubted case of syphilitic epididymitis until after the first year. The point made by Dr. Sturgis I have looked upon as well founded, that if there is any tenderness it is due to same accidental cause.

DR. R. W. TAYLOR.—I was astonished on reading Arthur Cooper's article in which he reported his one case, to learn that the English profession knows apparently little about this trouble. I was further surprised to know that Sigmund could have heard of it and yet did not believe in it. I have seen syphilitic epididymitis as early as the second month and as late as the first year. After the first year I would not consider it early epididymitis.

With regard to pain, it is generally present at the commencement, sometimes nocturnal, sometimes continuous. I have seen late syphilitic epididymitis breaking down. This form does not. I believe the lesion is simply a proliferation of connective tissue. As it gets old it becomes hard.

DR. A. T. CABOT, of Boston, read a paper on

PROSTATOTOMY FOR OBSTRUCTION.¹

DR. OTIS.—It seems to me the claim of Mr. Harrison with regard to the effect upon the prostate of passing the sound through the urethra is contrary to our belief of the manner in which prostatic hypertrophy takes place. The effect of the dilatation must be temporary, and we should consider the fact that in old people the passage of an instrument is apt to cause dangerous,

¹ Will be published in a subsequent number of this Journal.

and not unfrequently, fatal trouble. From what I have seen of obstructions at the neck, I think there is not very rarely a slight fold which may be divided, if we can distinctly make it out, by the method of Mercier. But all such operations in the urethra are very uncertain, and the danger of irritation is always a great objection to them. It seems to me that after having thoroughly demonstrated the obstruction, the proper treatment is to reach it through the perinaeum. The drainage would then be very free.

DR. J. H. BRINTON, of Philadelphia.—I have had a number of cases of incision through the perinaeum for hypertrophy of the prostate, followed by free drainage, and that method has always seemed to me to furnish the best results. I have never had any satisfactory experience in endeavoring to divide these prostatic enlargements through the urethra. The dangers of the procedure and the uncertainty of the results have led me to choose in preference thereto free perineal incision.

THE PRESIDENT.—I have seen a number of these instruments, and went so far once as to devise an *écraseur* somewhat like that of Mercier, but I have never employed it through the urethra. The cutting operation through the perinaeum is so much simpler, so harmless, and so effective for obtaining drainage, that I think it would not be good surgery nor just to our patients to try the other procedure. I think the benefits obtained by Harrison's method are due to blunting the sensitiveness of the deep urethra by the passage of the obtuse sound. I do not think any reduction in the prostatic hypertrophy takes place from the passage of instruments through the deep urethra, and that the benefit experienced is only temporary. Some fever and disturbance usually follow the cutting operation, but not serious.

DR. BRYSON.—I have had three of these cases in which I did the perineal operation; in all there were slight fever. I believe in making a free opening for the drainage tube along the floor of the prostate and leaving it in as long as the patient will allow or as long as it seems to be doing good.

DR. CABOT.—The introduction of instruments through the urethra in the first stages of prostatic trouble, it seems to me, does more harm than good, tending rather to aggravate the congestion and thus leading to hypertrophy of the prostate.

DR. E. L. KEYES, of New York, read a paper upon

A PLEA FOR THE MORE GENERAL USE OF NITRATE OF SILVER IN THE DEEP URETHRA, WITH AN IMPROVED INSTRUMENT FOR ITS APPLICATION.

DR. H. J. BRINTON.—My experience for the past twenty years goes to confirm that of the author of the paper. I have during that time employed deep-seated urethral injections of nitrate of silver in strong solution, from ten to forty grains to the ounce, putting in a few drops at a time with Acton's instrument, the lateral holes being closed, the central one being open. In the great majority of cases I find these deep injections of extreme value. Occasionally one sees a case in which they are of no avail. The solution should be introduced drop by drop, well forward.

DR. KEYES.—If after the injection you can squeeze out a drop of liquid, it shows the fluid was deposited anterior to the triangular ligament, and will do no good, but may set up irritation.

DR. OTIS.—The author has demonstrated the great value of making these injections at the precise location of the disease, and also the great importance of using a very small quantity of the fluid. He overlooks that large proportion of cases of cystitis or prostatitis due entirely to the presence of stricture in the anterior urethra. I have seen these cases, and also cases of recurring double epididymitis, relieved by division of an apparently insignificant urethral stricture.

DR. F. R. STURGIS.—I have used nitrate of silver injections applied with Bumstead's instrument and by means of a swab with often exceedingly good results, particularly in nocturnal emissions, and certain deep urethral irrita-

tions. But I have never used these applications in acute cystitis or prostatitis. I use twenty to thirty grains to the ounce, which I think is better than to use five to ten grains; the effect is better and more permanent. The irritation caused by the application has been very slight, passing off soon, certainly within twenty-four hours. Perhaps less of the solution reaches the mucous membrane when it is applied on cotton.

DR. GREENOUGH.—I had been rather prejudiced against the use of strong solutions of nitrate of silver in the urethra, but recently I have employed them, and in some cases with apparently very good effects. The only restriction I would put upon the paper is, that being a plea for the more general use of this agent, the author has perhaps not insisted sufficiently upon its dangers. If not applied with skill the injections are liable to do harm. That, however, is also true of ordinary astringent injections for gonorrhœa, and it is not improbable that the mass of the people would be better off to-day if such injections had never been made.

DR. HYDE.—I have made the injections, but always with the Bumstead instrument, and with weaker solutions.

DR. MASTIN.—I have been in the habit of using Bumstead's instrument, and have found the same objection to it Dr. Sturgis has mentioned, namely, that it clogs. Then I have used an ordinary stiff catheter for the purpose, injecting through it a weak solution, five to ten grains in strength. I have had much success with it. I would mention here that Dr. Richardson, of the University of Louisiana, has spoken to me several times on the use of an almost saturated solution of nitrate of silver introduced into the bladder in drachm doses in gonorrhœa and chronic cystitis. He claims great success from it.

DR. MORROW.—Formerly I used injections of nitrate of silver a good deal, following the plan of Sir Henry Thompson, using a strength of from two to fifteen grains to the ounce. The results were not so satisfactory as to lead me to continue the treatment. I believe, however, that with the improved instruments devised within the past few years, especially that of Dr. Keyes, better results will be secured. Dr. Keyes's results are certainly most admirable and satisfactory.

DR. CABOT.—I have used the injections in a great many cases the past two years with some brilliant cures; a great many cases benefited to a certain extent, and returning occasionally for the injections, and in others complete failure. I was so impressed with the importance of putting the injection at the apex of the prostate that I went so far as to modify Ultzman's syringe to admit of this, and made an instrument not unlike the one presented by Dr. Keyes. The openings are not at the point, but on the sides of the instrument near the point. I have rarely used more than five grains to the ounce. I have had excellent effects from irrigation of the prostatic urethra with a large quantity of a solution of acetate of zinc, three or four grains to the ounce. The fluid can be immediately drawn off after the injection, or the patient may pass it on rising.

DR. R. W. TAYLOR.—I have been using these injections since 1872, with very much the experience related by Dr. Keyes, the instrument employed by me being a modification of Bumstead's. I think Dr. Keyes's instrument has an advantage over mine in that it has no coupling at this point, but I do not think it is as suitably shaped at the end. The blunt instrument is more likely to catch on some folds and be disagreeable to nervous patients than one of acorn-shape.

DR. KEYES.—The customary result, in most instances, if the patient has considerable inflammatory disturbance to start with, is at once after the injection to feel a little throbbing, and a desire to urinate, but in ordinary cases there is no sensation whatever for about thirty seconds; then a slight feeling of heat, and a moderate desire to urinate, which in a few minutes becomes urgent. Sometimes the pain is quite considerable, so that the

patient feels that he must lie down. This may last two hours; it very rarely occurs at all.

As to the dangers of the method in unskilled hands, there can be no doubt about it, but those who are capable and careful, and go about it in the right way, will profit by it, while others will not.

As to the bluntness of the instrument, I think Dr. Taylor holds entirely wrong views. Being blunt, it fills the urethra, and prevents the fluid from coming back. As to Dr. Cabot's suggestion regarding the curve, I first made it in the way he thinks is best, but afterwards lengthened it, finding that better.

DR. BRINTON.—Allusion has been made to the period of pain which accompanies the treatment. For a good many years past I have employed a means of relieving pain after all forms of interference with the urethra which has never failed me. It consists in directing a small stream of water upon the corona glandis after the operation, and in three-quarters of a minute or a minute the pain will have ceased.

DR. TAYLOR, of New York, read a paper upon

A RARE FORM OF SEPTICÆMIA FOLLOWING OPERATION FOR URETHRAL STRICTURE: *Septicémie Foudroyante Gazeuse.*

DR. CABOT.—I have seen a case somewhat similar to, but milder than, the one described. The patient, a man aged forty-one, entered the Massachusetts Hospital two years ago. He had trouble with micturition, and a stricture was found. The urine contained traces of albumen and a few casts before the operation. He was divulsed August 15, 1885. The catheter was tied in. August 17th he suddenly had a chill. The catheter was then at once removed. August 23d, five days later, the perineum was bulging, and was opened on the following day and pus was evacuated. A wide opening was made and a tube was introduced into the bladder through the perineal wound, giving free drainage. Tenderness began to develop over both shoulders and clavicle, also in the neighborhood of the elbow, where there was redness. Three days later the shoulder was emphysematous, and a distinctly crackling sound was produced on pressure over the inflamed parts. An opening being made an extremely fetid abscess discharged. I came in charge of the case the 1st of September, when there was an abscess on the front of the leg, another over the shoulder, and a small one on the side of the penis. I opened the abscess, and on the 5th of September introduced a catheter through the urethra into the bladder, and from that time the case progressed steadily to recovery.

THE PRESIDENT.—I have had one such case after perineal urethrotomy in Bellevue Hospital, about 1870. The case occurred in a weakly, debilitated man, with a very bad stricture. Within a day or two after perineal urethrotomy an emphysematous condition suddenly occurred, extending around on one of the thighs, perhaps on both; it crackled, and the integument was dark. By evening the whole body was puffed up, and the patient died in a most violent way. There was no infiltration of urine in this case.

DR. TAYLOR then

EXHIBITED SECTIONS OF TUBERCULAR TESTIS WITH BACILLI AND OF THE CO-EXISTENT BACILLI IN THE SPUTUM.

THE PRESIDENT.—There is no doubt in my mind that if the existence of the tubercle bacillus be conceded, as it is by nearly everybody, its ravages are purely a question of soil. A man may have a chronic, a diffuse orchitis, a more or less diffuse epididymitis, undoubtedly tubercular in origin, which may break down into an abscess, and perhaps result in a permanent fistula, the trouble remaining localized and doing no other harm.

DR. BRYSON.—About a year ago I published a series of twenty cases of tubercular disease of the genito-urinary organs. Recently I removed a testicle in which the tuberculosis seemed to have begun in the testicle. Three tubercular masses could be felt through the soft parts. I performed the operation, observing antisepsis, and union by first intention took place. I was well pleased with the action of the bone drainage tube. I could detect no tubercular trouble about the prostate and neck of the bladder, nor was there any evidence of tubercular disease along the urinary passages. The bacillus tuberculosis was not found in the urine; but by squeezing the cut end of the vas deferens, after the testicle had been removed, I succeeded in getting out a very small quantity of fluid, which was found to contain the bacillus.

In all the cases I have observed there has been evidence sooner or later of the prostatic region becoming involved. Before excluding tubercular disease, I think careful examination of this region should be made, and that the urine first passed should be examined for the tubercle bacillus. In all my cases there was between the prostate and anterior rectal wall a small mass which felt like a phlebolite, but not so hard. I called attention to the fact that that mass can be made to slide on the capsule of the prostate and rectum. At the death of the patient I had this mass cut out, and it felt like a cheesy mass in the vein, and I took it to be a cheesy or tubercular localized phlebitis.

DR. CABOT.—I have noticed this pea-like body between the prostate and rectal wall in three cases. I had supposed it was a cheesy, lymphatic gland.

THE PRESIDENT.—I have noticed the same thing, but do not know that I have felt it in every case. I have seen a number of cases in which the tuberculosis seemed to be primary in the testicle. But generally, if not always, it commences, I think, in the seminal ducts, although it may get well there and travel down to the testicle and apparently become localized there.

Reviews.

DERMATITIS VENENATA. An Account of the Action of External Irritants Upon the Skin. By JAMES C. WHITE, M.D., Professor of Dermatology, Harvard University, etc. Boston: Cupples & Hurd. 1887.

UNDER the above title Professor White has grouped together the external agencies capable of causing, when applied to the cutaneous surface, inflammatory disturbance varying in severity according to the nature of the irritant, the conditions of its contact and the susceptibility of the skin.

The author duly emphasizes the fact that individual susceptibility plays an important rôle in the production of these cutaneous disorders. An irritant substance applied to the skin of several persons does not determine in all the same form or degree of irritation. Its action is especially subordinate to conditions of susceptibility inherent in the individual.

The importance of this work, both from a practical and scientific standpoint, is evident. A knowledge of the etiology of disease is essential to a recognition of its nature and proper treatment, and, since the changes in the skin caused by external irritants often closely simulate those of internal origin, this knowledge is no less important for purposes of differential diagnosis.

No one is better fitted than Professor White for the preparation of a work of this nature. For several years he has devoted special attention to the study of the irritant effects of external agents upon the skin. His investigations into the poisonous qualities of the different species of *rhus*, *arnica* dermatitis, arsenic in wall papers, etc., the results of which have been previously published, have constituted him an authority upon these subjects.

In the first section, devoted to the pathology of dermatitis venenata, the author considers the anatomical characters of the cutaneous changes. Almost every elementary form of lesion of which the skin is capable—erythema, wheals, papules, vesicles, bullae, pustules, and the secondary lesions, scales, crusts, excoriations, ulcers, etc., occur as the direct result of the contact of external irritants. The major part of the work is devoted to the study of the pathogenetic effects of agents derived from the vegetable kingdom. The number and names of plants containing principles poisonous to the skin will be a surprise and a revelation to most physicians. No fewer than sixty indigenous to this country, are enumerated to which such action has been attributed by good authority. The list embraces a large number of agents which are in common use and more or less esteemed for their medicinal qualities, and a knowledge of their incidental ill effects is therefore all the more important. Physicians who are in the habit of prescribing certain well-known and popular remedies, under the impression that they can do no harm even if they do no good, should be acquainted with the fact that they sometimes occasion the most violent tegumentary disturbance. The second division of the work is devoted to the consideration of the action upon the skin of other irritants, organic and inorganic. The reader will here find a complete account of the cutaneous effects of drugs employed for therapeutical purposes, as well as those which incidentally result from their commercial use. The dermatoses provoked by dye stuffs and pigments in articles of clothing and adornment, in the manufacture of wall papers and various articles in domestic use, are fully considered.

The book concludes with a description of the skin lesions caused by animal irritants.

We take pleasure in commending this work to our readers, both specialists and general practitioners, as a repository of much careful and original observation upon a subject of great practical interest and importance.

ELEMENTARY MICROSCOPICAL TECHNOLOGY. A MANUAL FOR STUDENTS OF MICROSCOPY. PART I. By Frank L. James, Ph.D., M.D., President St. Louis Society of Microscopists, etc. St. Louis Medical and Surgical Journal Company. 1887.

This little manual, according to the author, is designed to instruct students in the manipulations and processes incident to the preparation of material for microscopical examination. The present volume is devoted entirely to elementary technology and details the technical history of a slide from the crude materials up to the finished mount. It constitutes the first part of a work on General Microscopical Technology constructed upon the same scheme and plan. We commend the work as clear, concise, and eminently practical.

Correspondence.

THE CUTANEOUS PUNCH.

EDW. L. KEYES, M.D.:

DEAR DOCTOR—Having seen your article in the March number of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES, on the subject of the "Cutaneous Punch," I wish to call your attention to the fact that an instrument for the same purpose and of similar construction was used by me in 1877, and was fully described in two articles published—one in the *N. Y. Medical Record*, July 27, 1878, page 78, entitled "Discotome," and the other in the *St. Louis Medical and Surgical Journal*, Vol. XXXV., page 145, entitled "Gunpowder Disfigurements." From your remark that you had not seen these instruments described, I judge that you will be interested in the facts to which I have here alluded.

Yours sincerely,

B. A. WATSON.

To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES:

DEAR DOCTOR—The above communication explains itself. I am entirely unconscious of ever having seen either of the articles referred to above, and it is curious that no member present at the Dermatological Society when I read my paper entitled "The Cutaneous Punch," had any knowledge of any such instrument. It is no uncommon thing for an old instrument to be invented over again, as was surely the case in this instance—but it is only just to Dr. Watson that he should have the credit of priority if he wishes it, and the publication in your journal of his letter with mine will give it to him.

Yours very truly,

E. L. KEYES.

Selections.

MECHANICAL TREATMENT OF PAINFUL ERECTION.

ONE of the most constant phenomena of gonorrhœa is the production of involuntary, painful erection. It is of a reflex nature which may have as a starting point either a cerebral act, such as a dream, a recollection or an erotic desire, or may proceed from a sensation localized in the genital organs. It is the latter cause which appears to act principally in gonorrhœa. Neisser's gonococcus has penetrated within the canal and has provoked an intense specific inflammation. Sensation is very active in these sensitive organs. The spinal marrow has an impression made upon it, and does not delay in reacting by provoking a turgesence of the organ. If we add the factors of youthful age and forced continence, we readily see how the erections are apt to be frequent. It is especially at night that they are produced, the excito-motor power of the spinal cord freed from the moderating influence of the brain can develop with its maximum intensity. The heat of the bed,

the dorsal decubitus, the full condition of the urinary bladder are all additional causes which must be taken into consideration.

As to the pain experienced, the peculiar sensitiveness of the organ sufficiently explains its intensity. Regarding the mechanism of its production Dr. Diday, says: "The urethral walls rendered inextensible by reason of inflammation refuse to follow the cavernous body in their physiological turgescence whence painful tension of the canal, stretched as it is like the arc of a cord, of which the cavernous bodies furnish the curve."

To cure this painful condition all sorts of plans have been recommended, and some of the ancient recommendations are very remarkable.

As a preventive measure it has been recommended "never to sleep upon the back, always upon as hard a bed as possible or at least upon a hair mattress, with the aim of preventing an excess of heat during sleep. Baths and cold applications are advised.

The most important remedies and those in which the most confidence is to be placed are:

Camphor administered in pill form or as a clyster.

The bromide of potassium.

The bromide of camphor.

Hashisch alone or joined with benzoic acid.

Injections of morphine in the perineal region or, as Bonlounier prefers, in the lumbar region in the neighborhood of the genito-spinal centre.

Certain procedures are directed to the momentary cessation of the erection, but it may be said that aside from the application of cold none have great chance of succeeding.

It is recommended to stand in bare feet upon a cold floor or oil cloth; to place one's self in a knee-elbow position, after the manner of a Mohammedan salutation. Rupturing the chordee is a barbarity which while giving a relief of short duration, exposes the patient to the most grave stricture and the dangers of infiltration of urine. Seeking relief in connection Diday has qualified as an "immoral, inefficient and harmful practice." Dr. Shane, of Salem, Ohio, has advised an ice bag to the perinæum.

Campana has brought forward a rubber tube to encircle the organ and through which cold water flows.

Holbrook Curtis has constructed a sound which permits several quarts of water at 150° F. to pass through the canal.

Mechanical treatment is not so rich in devices, nor does it seem to have given results more favorable. Gilbert speaks of attaching the penis to the thigh, and Bosquillon strongly recommends the procedure; attaching the penis to the scrotum with adhesive straps is rejected by both Diday and Fournier.

The author recommends that the penis be maintained in the position from which he has observed many sufferers to find relief. Having observed men with gonorrhœa bend the penis down upon the perinæum and maintain it here by crossing the legs, and thus find temporary relief, he devised a bandage which would fulfill this indication. It is composed of an abdominal bandage having attached behind two perineal bands, separated so as to pass exactly in the glutod-femoral fold. These bands are continuous in front with a broad band of thick linen terminating in three straps.

It is applied by first fastening the abdominal belt securely, bringing the posterior bands forward in the glutod-femoral fold; the penis is pressed upon

the perinæum and slips between the two testicles, and the broad bandage covers the organs in, and the straps are drawn tight to hold them well in place.

Twelve patients with severe and painful chordee were thus treated, and all with marked success.

The author concludes :

1. The apparatus keeps down the erection and quiets the pain.
2. It calms the pain by preventing the erection of the organ and consequent tension of the canal.
3. The number of calls to urinate is often diminished, for the erection provokes the desire to pass water, and the patients urinate to overcome the erection.
4. It is possible that this mechanical treatment may afford relief in certain other morbid erections.—*Lyon Medical*, 20 March, 1887.

THE TREATMENT OF GONORRHŒA BY INJECTIONS OF IODOFORM OIL.

DR. THIÉRY (*Le Progrès Medical*, March 3, 1887,) says, that amongst diseases of the genito-urinary tract few have called forth methods of treatment at once so numerous and so inefficient as gonorrhœa, and this multiplicity itself shows the difficulties to be encountered by the physician when he undertakes the care of this malady, so common and so productive of grave consequences. The patient demands prompt relief, and the aim of the physician is not only to accomplish this but to secure a radical cure.

Now, gonorrhœa left to itself tends to spontaneous resolution, and although a bacterian disease, it has a well-marked cyclic evolution and is often seen to get well without any treatment. This, however, is the exception, largely because of the imprudence of the patient, whose excesses cause the gonorrhœa to pass into a chronic state, and it is this chronic gonorrhœa which is so frequent and so rebellious.

Three methods of treatment may be employed. The expectant which sometimes succeeds; the emollient followed by balsams, and the abortive. We employ at the Midi Hospital the second method in preference to the others, from having observed its good results, and we do not hesitate to say that the treatment, properly carried out, almost always succeeds when the patient can be managed and is desirous of a complete cure. The following is the plan followed:

In the First Period. 1. Patients are absolutely forbidden to drink beer, coffee, liquors or white wine, or to visit women, and are to be cautioned about touching the eyes with the hands.

2. Three times per week they are to take a full bath of an hour's duration.

3. Water colored with red wine may be taken with meals, but no other drink is allowed. Each day, between meals, a quart of water is to be drunk, in which forty-five grains of bicarbonate of soda has been dissolved.

4. A suspensory bandage is to be worn.

Second Period.—1. The same rules are to be observed as laid down under Section 1 of preceding rules.

2. The baths and bicarbonate are to be omitted and no liquid is to be taken between meals.

3. Six large pills of the following confection are to be taken each day.

R. Pulv. Cubebæ.

Pulv. Copaviæ.....āā ̄ j

Magnesie.....q. s. ut. ft. Confect.

If all these conditions are filled, and if the directions are carried out in all their details, and all the deprivations which they entail are put up with, success may be guaranteed. Wine and women have however such strong attractions for the hospital population (and they are so urgent in their demand for a speedy cure, that abortive treatment was introduced). This, however, is painful, and in inexperienced hands dangerous, and in most cases should be rejected.

The author, after using bichloride, nitrate of silver and other injections, has met with greater success in the employment of iodoform suspended in oil, a means of treatment which he characterizes as "active, rapid and absolutely innocuous." After trying saturated solutions of iodoform in ether, which were found too painful, a mixture of ether, iodoform and oil of sweet almonds was used, but both were given up in favor of a simple suspension of iodoform in the oil. About two drachms are injected in the usual way, after urinating, and retained for some time in the canal. The claim is made that iodoform adds to the antiseptic and microbial action an analgesic property which is of great value.

The odor of the drug is found to be sufficiently hidden by the addition of vanilline, coumarine, or spirits of eucalyptus.

Six cases are reported which were treated in the manner described; five were completely cured in from five to twenty-eight days, and the sixth was nearly well on the sixth day of treatment, when he left the hospital, making an average of thirteen days. From eight to twenty-nine injections were given.

Item.

ACUTE PEMPHIGUS.—Senator (*Deutsche Med. Wochensch.*, No. 1, 1886) describes a case of acute pemphigus. A healthy girl, aged 16, after being sick for two days with fever, pains in the neck, and presenting an eruption of maculæ of the extremities, trunk, and face, on the third day was the subject of discrete bullæ filled with pus, and of the size of a pea to a hazel-nut, resting on an infiltrated basis. On the fourth day of the disease there were no more bullæ. Cure took place without cicatrix. Senator does not consider a case of this kind to be a primary affection of the skin, but groups it with the acute exanthemata.—*London Med. Record.*

EDITORIAL NOTE.

AMERICAN ASSOCIATION OF GENITO-URINARY SURGEONS.

IN order to favor our readers with the Official Report of the Transactions of the American Association of Genito-Urinary Surgeons the present number of this JOURNAL has been enlarged by the addition of eight pages of reading matter. A number of the more important papers presented before the Association will be published in full.

The admirable work done at the first meeting augurs for this new association a career of great usefulness and prosperity.

Books and Journals Received.

PUBLIC HEALTH. The Lomb Prize Essays of the American Public Health Association. Comprising four valuable papers, viz:

- I. Healthy Homes and Food for the Working Classes. By Victor C. Vaughan, M.D., Ph.D.
- II. The Sanitary Condition and Necessities of School-Houses and School Life. D. F. Lincoln, M.D.
- III. Disinfection and Individual Prophylaxis Against Infectious Diseases. By George M. Sternburg, M.D.
- IV. Preventable Causes of Disease, Injury and Death in American Manufactories and Workshops, and the Best Means and Appliances for Preventing and Avoiding Them. By George H. Ireland, M.D.

On Some Important Points in the Treatment of Deep Urethral Stricture. By F. N. Otis, M.D. Reprint.

Practical Observations on the Gonococcus and Roux's Method of Confirming its Identity. By C. W. Allen, M.D. Reprint.

Mode of Development and Course of Molluscum Fibrosum and of the Question of its Relation to Acrochordon and other Cutaneous Outshoots. By R. W. Taylor, M.D. Reprint.

A Further Contribution to the Study of Molluscum Fibrosum. Etiology; Fibromatous Infiltration and its Relation to Keloid. By R. W. Taylor, M.D. Reprint.

Papers on Hypertrophy of the Prostate Muscle. By Reginald Harrison, M.D. Reprint.

Dermatological Notes. By J. Clark McGuire, M.D. Reprint.

Über das Ödema Indurativum (Sigmund), Ödema Scleroticum (Pick). Von Ernest Finger. Reprint.

Über Behandlung der Syphilis mit Injektionen von Calomel und von Quicksilber Oxyden. Von Dr. V. Watraszewski. Reprint.

Über den Einfluss des Erysipels auf Lupus. Von Dr. R. Winternitz. Reprint.

Demonstration von Hautkranken. Von Prof. F. J. Pick. Reprint.

Bartholinische Drüsen mit Doppelten Ausführungsgängen. Von Edward Lang. Reprint.

Elephantiasis Arabum of the External Genitals of a Negress. By Drs. W. E. Moseby and R. B. Morrison. Reprint.

Baldness, What can we do for It? By G. T. Jackson, M.D. Reprint.

JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

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VOL. V.

AUGUST, 1887.

No. 8.

Original Communications.

IDIOSYNCRASY AS AFFECTING THE SPECIFIC TREATMENT
OF SYPHILIS.¹

BY

PRINCE A. MORROW, A.M., M.D.

THERE is, perhaps, no other disease that the physician undertakes to treat with the same absolute confidence in his ability to accomplish certain definite results as syphilis. This confidence is amply justified by clinical experience, which has demonstrated in the most positive manner the undoubted efficacy of mercury and iodide of potassium in modifying the manifestations of syphilis and hastening their cure.

These two drugs which form the basis of all special therapeutic treatment at the present day, are by common consent ranked as *specifics*, since, when introduced into the organism, they directly attack and cause to disappear the organic lesions, as well as the functional disorders created by the syphilitic virus.

Notwithstanding the treatment of syphilis rests upon this solid basis of the demonstrated specificity of mercury and iodide of potassium, yet we find that their therapeutic virtues are by no means constant and infallible. Experience has

¹ Read before the American Association of Genito-Urinary Surgeons, May 17, 1887.

shown that different individuals exhibit a vast difference in their susceptibility to the action of these drugs.

While in the large proportion of cases, the syphilitic manifestations respond with surprising promptitude to the impression of these agents, oftentimes vanishing with marvelous rapidity, in other cases the symptoms prove refractory, the syphilitic organism remains absolutely insensible to their curative action, or, indeed, exceptionally specific treatment seems to intensify and aggravate the pathological tendencies created by the disease.

In still another class of cases, the organism rebels outright against the drug, and if its use be persisted in after indications of intolerance have declared themselves, remonstrates by signs of local or constitutional disorder, which may surpass in severity the symptoms of the disease itself.

This extraordinary variation in the curative action of mercury and iodide of potassium in syphilis must be attributed to physiological peculiarities of constitution, comprehended under the general term idiosyncrasy. While this term may be readily defined, it is none the less mysterious in its essential nature. Its existence is revealed by no outward sign, but the definite peculiarities of organization which constitute it, exert an active influence in modifying and dominating drug action. That one individual may take full doses of mercury for months without sensible impairment of the general health, while in another a single small dose will determine severe salivation; that one individual may absorb massive doses of iodide of potassium for an indefinite period, without any special deleterious effect, while in another individual a fraction of a grain of the same salt will promptly produce toxic symptoms, are facts of every-day observation. They prove that in the production of drug effects the organism plays the principal rôle, and that the therapeutic action of specific remedies is especially subordinate to conditions of aptitude inherent in the individual.

It becomes a proper subject of inquiry how far the incidental ill effects of specifics in syphilis are to be accepted as a contra-indication of their employment.

The motive of this paper will be found in cases occurring under the author's personal observation, in which intolerance of specific treatment was so pronounced as to seemingly constitute a fixed, insurmountable obstacle to the continued use of the offending drug. It is not designed in any sense to be dogmatic, but rather suggestive, in bringing before this Association for

purposes of discussion the practical significance of the different phases of idiosyncrasy and their bearing upon treatment.

Idiosyncrasy in relation to the action of mercury and iodide of potassium may be manifest in various modes and degrees of intensity.

1st. In an extraordinary susceptibility to their physiological or toxic effects.

2d. In the production of incidental ill effects determined towards the cutaneous and mucous surfaces or other organs. These ill effects may be associated with the drug's physiological action, or they may substitute it, constituting an aberration of their typical mode of action.

3d. In an insensibility, or failure on the part of the organism to respond to their curative action, as regards the first class of effects. Every physician who has much to do with the treatment of syphilis must have encountered cases in which ordinary medicinal doses of mercury and iodide of potassium have produced toxic effects. I have observed in dispensary practice more than a score of cases in which doses of $\frac{1}{2}$ grain of the protiodide, or $\frac{1}{32}$ grain of the bichloride have been followed by the prompt occurrence of toxic symptoms. I distinctly recall the case of a young woman with a sparsely developed papular syphilide for whom I ordered pills of the protiodide ($\frac{1}{2}$ grain), who returned in three days with an extremely violent stomatitis, swelling and protrusion of the tongue, and a most profuse foetid salivary flow. Cases are on record in which intense symptoms of "Hydrargyrisms" have been caused by a single minute dose of calomel, exposure to the fumes of mercurial vapor, a single friction with mercurial ointment, etc.

The varied phenomena of hydrargyrisms are of course too familiar to be described here. The severer forms are referred to by modern authorities as possessing only historical interest, from which patients at the present day are fortunately exempt, since the abuse of mercury has been supplanted by its more rational employment. They are, however, by no means rare—although not designedly produced as formerly, they are often inadvertently developed in idiosyncratic patients by ordinary medicinal doses. They are not dependent upon the quantity of mercury employed, the preparation, or the mode of administration, but appear to rise from an idiosyncrasy or peculiarity of constitution of the patient.

It is generally taught that an extraordinary susceptibility to the action of mercury does not constitute a contra-indication

to its use. The gastric intolerance of the drug has received much consideration. The endless efforts which have been made to improve and perfect therapeutic methods are chiefly due to a recognition of the disturbing effects of mercury upon the gastric functions: these have been sought to be obviated by the use of corrigents, substituting other preparations of the drug, or introducing it through different channels, by inunctions, fumigations, or hypodermatically. Other incidental ill effects of mercury, unless very exaggerated, have been practically disregarded. The production of a mild stomatitis is accepted by many as salutary rather than otherwise—as an evidence that the drug is doing its legitimate curative work. I am disposed to believe, with Baumler, who says: “It cannot be denied that a mercurial treatment which quickly causes salivation and other evidences of mercurialism while it has but little influence on the syphilis causes great injury to the constitution of the patient.” Now, patients who manifest idiosyncratic intolerance of mercury cannot take it in *any* dose without the development of toxic symptoms. Minimizing the dose, or resorting to any of the various expedients which have been suggested, fail to obviate its ill effects, so that the inhibition of the toxic action of mercury in these cases is practically equivalent to its rejection as a means of treatment. Fortunately, abnormal susceptibility to both mercury and iodide of potassium is rarely manifest in the same individual. In persons who manifest an idiosyncrasy against mercury the substitution of iodide of potassium is recommended, even by those who deny the specific virtues of the latter drug in the secondary stage of syphilis.

The toxic effects of mercury upon the kidneys in the production of albuminaria and other renal disorders, its profound impress upon the central nervous system manifest in mercurial tremor, erethismus mercurialis, and other symptoms of malignant hydrargyrisms, do not belong to the domain of idiosyncrasy. They occur, as a rule, when the drug is tolerated and taken in large doses for a considerable time.

In the second class of effects determined by idiosyncrasy there is often an abnormal susceptibility to the action of mercury and iodide of potassium, but, in addition, there may be incidental by-effects which have nothing to do with the drug's normal physiological action. These incidental effects are most commonly observed from iodide of potassium, and may be manifest upon the skin, the mucous surfaces and the central nervous system, constituting what is known as “iodism.” The symp-

tomatology of iodic eruptions embraces a vast number of cutaneous changes representing almost every possible form of lesion. As Hutchinson says: "Not even the syphilitic virus itself is capable of producing a greater multiplicity of pathological changes in the integument."

It will be readily conceded that the production of the simpler, more fugitive forms of iodic eruption does not contra-indicate the continued use of the drug. Indeed, the occurrence of the characteristic acneiform iodic eruption is accepted by many authorities as the necessary evidence that the full therapeutic efficacy of the drug has been obtained. Such an eruption, viewed in the aspect of a local accident, which invariably undergoes spontaneous evolution as soon as the exciting cause ceases to act, is not regarded as a serious affair. This conclusion may be legitimate enough in cases where the indefinitely prolonged use of the drug does not make any material change in the general characters of the eruption.

But in many cases these papulo-pustular lesions may become the starting point of severer forms of eruptive disturbance which may be associated with the toxic systemic effects of the drug. There is not only a disturbance of local nutrition, but a profound impress made upon the central nervous system, and the organism is thus placed in a condition most unfavorable to the processes of repair and cicatrization. In a careful study of iodic eruptions, I have found that the severer forms were almost always attended by symptoms of constitutional disturbance more or less severe. In nine cases of iodic bullous eruption recently reported by myself, there was a mortality of nearly fifty per cent. Hutchinson reports a case of a man whose body was covered with large soft tumors, big as a child's fist, from the use of the iodide of potassium in small doses. The patient died from exhaustion, apparently due to the extent of surface implicated. In almost all of these cases comparatively small doses of the drug produced the toxic symptoms. While cardiac and renal disorders may account for the fatal result in some of these cases, in others, post-mortem examination demonstrated the absence of all complications. It is evident then that however innocuous and inoffensive iodide of potassium may be in the majority of cases, yet physiological and pathological predispositions may exalt it to the character of a dangerous drug. I would especially insist that the occurrence of bullous, purpuric, anthracoid and other severe eruptive forms in a person taking iodide of potassium, should always be interpreted as a signal of danger, indi-

cating that the drug should be withdrawn or used with great circumspection.

When the disturbing effects of the iodide upon the gastrointestinal mucous membrane cannot be obviated by any of the expedients presently to be mentioned, the advantage of its continued employment is open to question. Its irritant action upon the conjunctival, nasal and bronchial mucous membranes, however disagreeable and annoying, cannot be regarded as a contra-indication to its use, except when it produces dangerous laryngeal symptoms, œdema of the glottis, etc.

The group of symptoms known as constitutional iodism, lassitude, muscular tremors, hebitude, parietic phenomena, psychical disturbances and various algias, due to the depressant action of the drug upon the brain and cord, although ordinarily resulting from its prolonged and excessive use, may, according to Rilliet, follow minimal doses of the drug.

No fewer than seven cases have recently come under my observation, in which the use of iodide of potassium in ordinary doses produced eruptive disturbances of various degrees of severity. In some of the cases, the subjective symptoms of burning and itching were so intense that the patients refused to continue the medicine. The group of cutaneous accidents embraced erythema multiforme, erythema nodosum, urticaria papulosa and bullosa, and, in one case, hemorrhagic bullæ.

The notes of this and the following case were kindly furnished by my house surgeon, Dr. Hogan.

CASE VI.—Delia Tietjen was in Charity Hospital two years ago for syphilis. Iodide of potassium, in increasing doses, caused an eruption, and mixed treatment made it worse.

She was again admitted April 3, 1887.

Treatment.—Blaud's pills, No. i. t. i. d. Pil. Hydrarg. Iod. Viridis, gr. ii. per day. K. I., \mathfrak{z} i t. i. d., increasing doses. Ung. Hydrarg. and Liq. Plumb. et Opii.

April 5, 1887.—A papulo-urticarial eruption was first noticed on forearms, specially extensor surfaces, slightly on posterior aspect of arms, and on anterior surfaces of thighs, legs, and all over feet, also forehead, cheeks, and scapular region on both sides of spine had a few spots of same. The previous afternoon and night patient was restless and somewhat delirious, requiring several doses of bromide and chloral to quiet her. The eruption on forearms, thighs, legs and feet had a decidedly hemorrhagic character, hemorrhagic bullæ existing here and there on the hands, elbows, and knees, while on inner side of right thigh, just above knee, there were patches of purpura as large

as one's hand. Patient complained much of a burning sensation in eruption, and feels nervous and shaky generally. Dose of K. I. 3 i of 1 in 4 sol. with 3 iii of syr. sarsaparilla co. t. i. d. Ordered all medication stopped, and patient remained in bed, where she has been for several days.

April 7th.—Eruption losing its urticarial appearance, and assumes appearance of red papules with tendency to deepen in color; some of the hemorrhagic ones tend to clear up, while in others, the hemorrhage becomes more marked. The purpuric patch on patient's thigh is fading fast. The few bullæ present are surrounded by red areolæ, and patient complains much of their paining her.

April 8th.—Patient complains little or none of the burning sensation or pain. Eruption steadily fading, assuming first a brown color, which becomes lighter, and then invisible. Can scarcely discern the purpuric patch on right thigh. The hemorrhagic tendency is now well marked about both feet. The same character of eruption was again developed by the resumption of the iodide.

In addition, there were observed on the outer side of upper third of left thigh, on calves of both legs, and superior border of left mammary glands, circumscribed swellings about the size of a silver quarter, painful and tender to the touch, about half an inch high, hard and erythematous, especially at apex. Intense burning sensations accompanied these eruptions.

CASE VII.—This patient, A. C. F., æt. 39, was sent to me by Dr. Hubbard, of Bridgeport, with the following history: "He contracted syphilis ten years ago; in October, 1886, he developed a tertiary rodent ulcer on the nose, and the ulceration returned also in the cavity of the fauces. Then I began to give iodides in increasing doses, but the larger I gave it, the less tolerant he became, so that now the dose which he used to tolerate without disturbances fills his face with bullous eruptions, most geometrical in form, and situated on an inflamed base of proliferated, granular-looking tissue. The blebs soon break, but so long as the iodide is continued they discharge freely a thin, watery fluid, and when it is discontinued they soon become dry, putting on the appearance of "psoriasis syphilitica." He has tried iodide of potassium and sodium, with and without mercurials, and Donovan's solution. He has had a variety of iodic eruptions: acne, and the peculiar bullous and other eruptions which he now exhibits. And it seems to me that the elevated patch on the back of the left hand is like the "ulcus elevatum," five cases of which were described by Dr. Seguin some time since, and were caused by bromide of potassium."

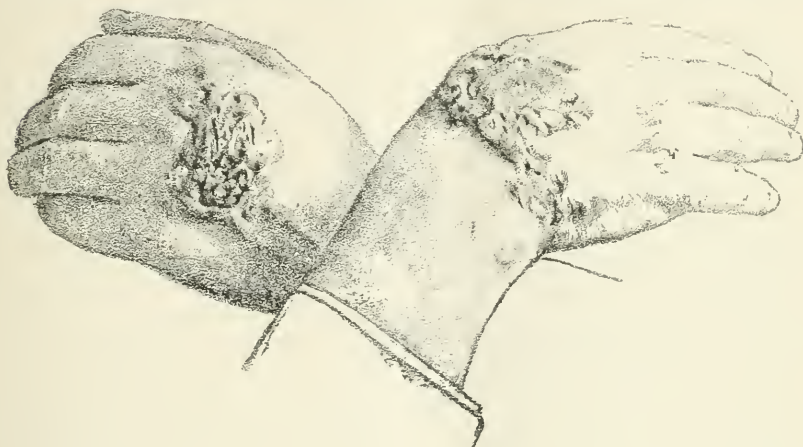
The patient came under my observation April 8th, and was sent to my ward in Charity Hospital.

He then exhibited a multiform eruption over face, neck and hands ; over right frontal eminence is a round erythematous patch about the size of a silver dollar, with raised outline, coated with a yellowish crust showing here and there minute whitish pustules ; upon the raised circumference are a few blebs. On a line from right frontal prominence to nasal spine are two patches, on erythematous bases, one about the size and shape of a bean, other somewhat smaller ; both have elevated, spongy, crustaceous coating ; upon pressure sero-pus exudes from several points through crust. Over nasal spine (interciliary space) is just such another but larger and more elevated patch with slightly inflamed base.

An oblong patch, with highly inflamed base, stretches over bridge of nose ; right half is lobulated from grouping of vesicles, other half is covered with a hard reddish crust. A large flat pustule covered with a thick brownish yellow crust involves the whole of right ala of nose. The whole of the nose is of a bright red color, hard and firm to the touch. Running across upper part of forehead from right frontal eminence to margin of hair below left temporal ridge is a reddish discoloration indicating site of former lesions. Here and there over this erythematous patch are several very minute pustules and vesicles and a bean-sized patch over left frontal eminence same as that over right. Running from margin of hair on left side following temporal ridge and margin of orbit to malar prominence is a narrow lesion, with highly inflamed base, resembling somewhat in shape the old letter S ; the upper half of the S is a series of pustules and vesicles having a thin gray crustaceous covering ; the lower part of the S is keloid in appearance, but soft to the touch, no tendency to rupture, but when punctured readily empties itself of sero-pus and refills rapidly. Small pustules and vesicles are found all over face and neck. Covering nape of neck is an H-shaped bullous eruption seated upon a slightly inflamed base. Involving whole of back of left hand is a circular patch composed of tubercous growths touching at their periphery with edge one-quarter inch broad, raised, red and tense, hard in appearance but soft to touch and easily ruptured, with depressed and yellowish coated centre. An erythematous halo surrounds the whole, one-half inch deep.

A series of pinkish tubercles, about the size and shape of a coffee bean, or larger, with broad erythematous base, form a line from styloid process of ulna to thenar prominence of right hand.

Back of left hand was occupied by a number of large tuberculous growths, circularly arranged and touching at their periphery.



Several large pea-sized sub-cutaneous, hard, movable nodules are found over cervical region.

Treatment.—He was ordered iodide of potassium in twenty-grain doses three times a day and Zittmann's decoction. Within forty-eight hours new lesions, pustular and bullous in character, appeared over the bridge of the nose, forehead, cheeks, chin and around the neck. The partially healed lesions on the face and back of neck became reddened and elevated at their edges from effusion of fluid, the keloidal lesions began to soften and exhibit here and there minute pustular points, the erythematous ring around the patches deepened in color and the skin became elevated as if by a blister from a scald.

April 30th, discharged at own request.

Was under my observation for two days longer. Belief was deeply rooted in the patient that the iodide of potassium was the only remedy for the ulceration; he insisted upon taking it with the result of developing ten lesions, of intensifying all the existing eruptive features and a continuous increase in the size and depth of the ulcers, and causing an excavation at the entrance of the nares to spread over the entire upper lip. This excavation was, I think, primarily caused by the irritant coryza, and I am sure was aggravated by the constant flow from the nostrils, so profuse as to saturate several handkerchiefs.

The topical application of mercury in the shape of the ung.

de vigo and the use of iodoform internally evidently renewed the inflammatory and suppurative process.

The constitutional symptoms were most pronounced, especially depression of spirits, irritability, pain in side, asthmatic symptoms and conjunctivitis. Patient had previously observed a vesicular eruption on eyeball from taking the iodide.

As I was unwilling to continue the iodide, the patient passed from my observation on the 10th.

An analysis of the clinical history of this case shows the following: A patient suffering from a tertiary ulceration of the nose threatening the destruction of this important organ, which demands prompt and energetic treatment. Under the influence of specific treatment new iodic lesions are constantly breaking out in the immediate neighborhood of the specific ulcer. Some of these pustular lesions break down, take on the impress of the syphilitic process and follow all the evolutions of specific ulceration, the specific disease constantly receiving with each accession of the iodic poisoning a fresh increment of pathological force—a sort of propulsion onward of the destructive tendency. Added to this there was a progressive enfeeblement of the vital forces, intense cephalalgia, insomnia, great irritability and excitement, iodine asthma, pain in the left side simulating pleurisy, conjunctivitis, coryza and intense pain, especially marked in the lesions upon the hands.

The rule of conduct laid down in such cases by a distinguished authority is as follows: "When an important organ is threatened, it is not necessary to ask whether the iodides agree or not. The dose must be increased by five or ten grains, and so on, indefinitely, until the symptoms yield, or the stomach refuses to receive the drug. Limit to the dose there is none; the signal to stop increasing the dose in a desperate case is unconditional surrender on the part of the symptoms."

The wisdom of this counsel is open to question, especially when, as in this case, the drug determines an intense dermatitis localized in the area, in which the syphilitic process is centered. The drug lesions were characterized by inflammatory products so nearly analogous to the specific lesions that it became impossible to differentiate them. I am satisfied that many persons are treated for syphilis whose eruption has been caused by the iodide of potassium. I am disposed to believe that in many cases when the irritant action of the iodide is determined towards the skin that the iodic lesions, like traumatism, from mechanical or chemical irritation, constitute new

foci of syphilitic ulceration. When, in addition, an iodine cachexia is engrafted upon the syphilitic diathesis, the system profoundly disturbed in its centres of nutrition, the reparative forces of the system are weakened, and the destructive tendencies of the disease are energized and aggravated. Hutchinson claims in cases where the iodide of potassium proves poisonous in ordinary doses, to have repeatedly cured tertiary ulcerations of the throat and skin by giving it in $\frac{1}{2}$ or $\frac{1}{3}$ grain doses. This result has not been verified by the clinical experience of others; besides, it is opposed to what we know of the laws of idiosyncrasy, since it is commonly observed that patients who manifest a marked antipathy to the drug cannot take it in any dose without coincident liability to irritant effects.

A variety of expedients have been recommended with the view of counteracting the incidental ill effects of the drug while continuing its use. Arsenic, aromatic spirits of ammonia, belladonna, sulphaniline have been recommended as possessing this corrective action. I have tried all of them, except sulphaniline, with indifferent success. The best means to secure toleration is the use of the drug in large quantities of an alkaline medium, as vichy water, or combined with agents which stimulate the functional activity of the kidneys, thus increasing their eliminating capacity. Besnier claims that the drug introduced hypodermatically does not occasion the same irritant effects as when given by the stomach. This observation has not been confirmed by others. Its introduction per rectum is usually disappointing. My own judgment is that in cases where idiosyncratic intolerance cannot be overcome or circumvented by any of the ordinary methods it would be better to discontinue specific treatment altogether, and have recourse to tonics, vegetable alteratives or other means of cure, relying largely upon local treatment. I have found that the use of peroxide of hydrogen has an admirable effect upon syphilitic ulcers, characterized by an abundant purulent discharge. Idiosyncrasy may be so marked as to render the local employment of mercury or iodoform in the form of ointment, or otherwise, impossible.

As this paper has already extended much beyond its proposed limits, I shall only briefly refer to the class of cases, fortunately rare, in which idiosyncrasy is manifest by an insensibility to the curative action of mercury and iodide of potassium. In this class of cases these drugs do not necessarily determine incidental ill effects, but there is a failure on the part of the syphilized organism to respond to their therapeutic specificity.

All observers have noted a marked difference in the susceptibility of different syphilitics to specific treatment—in some cases it seems inoperative or inert. The older observers, impressed with the extreme inequality in the results of the same treatment, sought its explanation in a plurality of viruses. They differentiated types of syphilis upon the basis of the curability of their manifestations. At the present day we recognize the fact that the benignity or malignity of syphilis, the multiplicity, succession and duration of its manifestations, as well as their curability, are largely determined by inherent differences in the individual.

In reference to this point, Mauriac says: "It is a most remarkable thing, the difference which exists between organisms in relation to their aptitude to conceive and fecundate the curative action which this order of medicinal (specifics) agents tend to develop in the economy. There are some forms of syphilis which relapse without end, and become more profound, permeating and destructive, notwithstanding the most rational employment of mercury and iodide of potassium."

I do not include in this category malignant, precocious syphilis, the ecthymatous and phagedenic forms occurring in cachectic persons, whose general health is profoundly altered by alcoholism, privation, misery and other factors of gravity in syphilis. It is well known that specific treatment is often positively pernicious. Under its influence, the necrobiotic process is intensified and all the symptoms are aggravated.

These cases, however, represent pathological rather than physiological predispositions, they are dyscrasias rather than idiosyncrasies. The conditions which cause them are susceptible of being corrected by good food, tonics and reconstituent remedies. The physician may then intervene with his specific treatment; there is a prompt response with the most satisfactory results. In the class of cases more particularly referred to there seems to be a lack of receptivity on the part of the system—an insensibility to the therapeutic action of mercury and iodide of potassium, quite irrespective of the type of the syphilis or the character of its manifestations. We observe the same insensibility of many malarias to quinine, of arthritisms to alkalies, of certain dermatoses to arsenic, and in such case the use of specifics is abandoned and other rational remedies substituted; but as regards syphilis there is such an absolute, unquestioning faith in the virtues of mercury and iodide of potassium to meet every possible contingency or exigency created by the disease that

recourse is seldom had to other remedies. Efforts have been directed with the view of improving and perfecting modes of administration rather than providing succedaneums in these cases in which constitutional peculiarities contra-indicate their employment or defeat their specific action.

As before intimated, this paper is intended to be suggestive in bringing up for discussion the question whether the influence of idiosyncrasy in modifying the action of specifics in syphilis has received the consideration from syphilographers that its importance demands. By many authorities the rule of the treatment of syphilis had been laid down as if all persons were alike—so many months of mercury, and after a certain date recourse to the iodide of potassium. A routine treatment has thus been vigorously and mathematically formulated without reference to the immense variance in the constitutions and idiosyncrasies of different patients, which is manifest not only in toleration of these drugs, but in susceptibility to their curative action.

I may conclude with the following suggestions:

1. Does idiosyncrasy expressed either in an abnormal susceptibility to the physiological action of mercury and iodide of potassium, or in the production of severe incidental ill effects constitute a contra-indication to their employment?

2. Is there not often a deplorable persistence in the use of these drugs when the system protests by evident and visible signs of suffering?

3. Should not these signs of intolerance be respected and deferred to, and should not the effects upon the patient be accepted as the measure of the activity and continuance of specific treatment?

4. Is not an absolute faith in the infallibility of mercury and iodide of potassium in syphilis often delusive, and has it not led to a neglect of other therapeutic resources?

CASES OF PYELITIS IN WHICH FREQUENT AND PAINFUL MICTURITION WAS THE CHIEF SYMPTOM.

BY

GEORGE CHISMORE, M.D.

CASE I.—E. C——, American; married; gunsmith. Habits good. Consulted me during a visit to Ilion, New York, in February, 1876. He was then 26 years old and gave the following history:

In the fall of 1869, while in the act of pulling a car containing 800 pounds of gun barrels on to the platform of an elevator, some one below started the elevator down ; realizing his great danger of being crushed he made a violent effort and succeeded in pushing the car back on to the floor so that it did not fall, having to lift a large part of its weight in order to do so. He was conscious of having "strained" himself, and in a day or two began to pass blood from the penis and to suffer from frequent and painful micturition. Up to this time his health had been good and he had never had any disease of the genito-urinary organs. He grew rapidly worse ; could retain his urine but two hours at best and had to pass it at times every ten minutes day and night.

The urine soon became loaded with pus and the doctor who attended him told him that he had an abscess of the kidney ; gave him but little medicine, no local treatment, and said he would soon be well.

Instead of improving, however, he grew steadily worse and was confined to the house most of the following winter. In the spring he got better and was able to work a little at his trade, although the micturition continued frequent and painful. He remained about the same during the summer and fall, but on the approach of winter was again obliged to give up work and remain in the house. He now called in another doctor who considered the case one of chronic cystitis and injected the bladder with a solution of nitrate of silver. He seemed to derive some temporary relief and the treatment was continued at intervals during the next two years (thirty-five injections in all). Finding himself gradually running down he went to the Stranger's Hospital in New York, and was under the care of Prof. F. N. Otis, who confirmed the diagnosis of chronic cystitis, washed out the bladder regularly and used milder injections. Not receiving any benefit he went to Buffalo and placed himself in the care of Dr. White ; subsequently he consulted Dr. Gray, of Utica ; both these gentlemen told him his trouble was inflammation of the bladder, treated him locally, but neither afforded him any relief.

By this time he became convinced that local treatment was useless ; indeed he thoroughly believed that every instrument passed into his bladder and injection used, in the end made him worse ; he therefore ceased to consult any one but took a number of nostrums and became addicted to the use of morphine to relieve his intolerable vesical distress. He remained an invalid,

unable to do any work, always better during the warm weather, but confined to the house winters.

In 1875 he received a blow on the perinæum that was followed by an abscess that left two rectal fistulæ. After this the pain and frequency of micturition notably lessened, but his general health was worse than ever.

When I saw him first, February 6, 1876, he was in a most pitiable condition, emaciated to the last degree, with a harassing cough, profuse night sweats, and the general look of an advanced case of phthisis. On examination I was surprised not to be able to find evidence of pulmonary tuberculosis. The urine was putrid, loaded with pus, but he was able to retain it longer and pass it with less pain than formerly, passing it on an average once an hour. There were two large fistulous openings between the coccyx and the anus, the larger admitting the tip of the little finger, both presenting that peculiar look of melting tissues common in advanced cases of consumption.

I took him to New York and met Drs. Van Buren and Keyes in consultation. Some one, I do not remember who, suggested pyelitis, but the diagnosis agreed upon was chronic cystitis. He was advised not to have any surgical interference with the fistulæ, to forego all local treatment of the bladder, and to take cod-liver oil regularly, and was sent home in the full expectation that he would presently sink from exhaustion and blood poisoning.

As the warm weather approached, he picked up a little and passed a more comfortable summer than usual. He took kindly to the cod-liver oil and gradually improved so much that he could get about during good weather. In 1879 or 1880, Dr. J. Rasbach, of Nion, discovered casts together with a considerable quantity of albumen in his urine and told him he had Bright's disease. About this time he began to suffer great pain at intervals over the region of the left kidney; this he was always able to relieve by cupping.

In the spring of 1882, he went to Dakota and improved greatly during the summer, but in the fall, pain more severe than ever set in over the left kidney; then a "lump" was noticed, which the doctor, who was called at once, opened freely. There was a profuse discharge of pus; the matter disappeared from the urine; he could retain his water almost as well as ever, and he grew rapidly better. The abscess required to be opened several times, finally healing soundly in 1883.

I am in receipt of a letter from him, dated March 2, 1887, in

which he states that he is as well as ever; can do hard, outdoor work on his farm; has ceased to use opium in any form; has regained his flesh; lost his cough, and, in fact, is to all appearances a healthy man. The rectal fistulæ healed without treatment or operation.

He has still a trace of albumen in the urine, but has no pain in the lumbar region, nor even the slightest distress or frequency in micturition.

CASE II.—S. F——, aged 23; American; single; farmer; habits good. Family history of tuberculosis. Saw him first in consultation with his regular attendant August 21, 1884. About a year previous while at work on his farm he strained his back lifting a heavy weight. Soon after he was seized with a chill which was supposed to be ague, as he lived in a malarial district; he then began to be troubled with frequent and painful micturition, although he *had never before had any disease of the genito-urinary organs*. The chills recurred at irregular intervals, were attended with fever, pain in the back and limbs, and followed by profuse perspiration. The irregularity was supposed to be due to the quinine, of which he took freely. Finding the distress of the bladder growing gradually worse, and his general condition rapidly running down, he came to San Francisco and placed himself in the care of Dr. Wanzer. His case was considered one of chronic cystitis, possibly due to stone, and I was called in to explore the bladder. He was then much emaciated and had an expression of constant suffering; could walk about, but was worse after doing so; appetite poor, sleep broken by constant calls to urinate and great pain in the bladder. Micturition was attended with pain in the bladder and head of the penis, but was followed by relief lasting a few minutes. At times could hold his water two hours; at others had to void it every ten minutes. There was no tenderness over the kidney, nor could anything abnormal be made out by palpation. Examination of the urine passed in 24 hours, 40 fluid ounces, slightly turbid, pale yellow, normal odor, acid, specific gravity 1.020; albumen a trace; sugar none; sediment moderately copious, white, ropy. Under the microscope nothing but pus could be made out. A careful exploration of the bladder and urethra gave negative results. Subsequent microscopical examinations threw no light upon the case beyond demonstrating the constant presence of pus in considerable quantity. After observing the case for a few days I came to the conclusion it was one of pyelitis, basing the opinion upon the evident presence

of grave disease of the genito-urinary system, the quantity of pus discharged daily, and the absence of any demonstrable lesion of the bladder or urethra. The attending physician was inclined to doubt this view of the case, pointing to the fact that there was neither pain nor tenderness in the lumbar region, nor could we feel a tumor or find microscopic débris of the kidney in the urine.

After this I lost sight of the case for about six months, when he was transferred to my care, the onward progress of the disease having confirmed my diagnosis. He was then passing large quantities of pus in his stools and very little in the urine, and coexistent with this change in the channel of discharge there had been a notable decrease of the vesical distress. Although he was now very much emaciated I could not elicit tenderness by palpation or distinguish a renal tumor, nor was there any complaint of pain in the back.

He gradually sank, and died March 28, 1885. On post-mortem examination the right kidney was found greatly enlarged, riddled with cavities lined with cheesy matter and containing pus. One of the largest cavities opened into the colon near the junction of its ascending and transverse portions. The right ureter was pervious and greatly dilated; the left kidney enlarged, but otherwise healthy. The walls of the bladder were somewhat thicker than usual, but *its mucous lining was apparently free from disease* of any kind; with the exception of the matting together of the colon and omentum, at the point where they were glued to the right kidney by adhesive inflammation, no other disease was noted.

I have selected these two cases from a number that have fallen under my observation for the purpose of calling attention to a fact noticed by nearly all text-books on diseases of the genito-urinary system, but never, in my judgment, sufficiently emphasized—*i. e.*, that frequent and painful micturition may be so prominent a symptom in a case of pyelitis as to mislead thoroughly competent observers as to the nature of the case and cause them to address treatment to the bladder alone, while the real malady is unrecognized and liable to be greatly aggravated by the mistake in diagnosis. I have given the names of the distinguished men who were thus deceived in Case No. 1, because they serve in the clearest manner to show the importance of this matter.

I well know that the case is open to the inference that the pyelitis was consequent upon cystitis, but I believe a fair view

of the whole field will lead to the conclusion that the trouble was in the kidney from the start. A violent muscular strain, the almost immediate appearance of blood in the urine, the absence of previous disease or causes thereof, the lack of demonstrable disease of the bladder and urethra, the onward progress, whether under treatment or not, and the final restoration to health after the suppurating kidney had obtained opportunity to discharge, seem to me conclusive as to the nature of the case.

The second case was probably hopeless from the start, and is reported because the diagnosis, verified by autopsy, was arrived at mainly by the exclusion of disease of the bladder and urethra, as no assistance was had from the examination of the urine, or physical exploration of the renal region.

If the cases bearing upon this subject that are scattered throughout the medical journals were collected, it would be surprising to note how many times a healthy bladder has been subjected to every variety of energetic and persistent treatment while grave destruction of the kidney has gone on unknown until lumbar abscess or post-mortem examination demonstrated its presence. References to several such cases admirably reported are appended. Nor has there been wanting a warning voice to call attention to this particular matter. In Braithwait's *Retrospect*, Part 33, July, 1856, page 123, *et seq.*, there is a most excellent paper by Dr. W. R. Basham, physician to Westminster Hospital, upon this very subject, in which, after giving a case, he summarizes the then known methods of diagnosis in the most masterly manner. Indeed, had he but added the broad generalization that in the presence of frequent and painful micturition with purulent urine and without history of venereal disease, or demonstrable lesion of the bladder or urethra, the surgeon should always suspect pyelitis, there would be no motive for this paper.

I do not go into the various methods of diagnosis of pyelitis by examination of the urine and physical exploration, interesting as the subject is, because when once the attention is directed to the kidney the object of this paper is attained; and for the further reason that in many cases chemical analysis and microscopical examination of the urine, palpation, thermometry, and all means of exploration at our command may fail to yield positive evidence, and the diagnosis in the end must be made by the method of exclusion.

The following articles upon the subject are referred to:

A case of cysto-pyelitis or pyelo-cystitis or cystitis coincident with pyelitis. By Edward O. Otis, M.D., Boston *Medical and Surgical Journal*, Vol. 110, 1884, March 27th, page 290.

Case of nephrotomy. By Dr. Roddick, Montreal General Hospital, Canada *Medical Record*, April, 1882. Noticed in *American Journal of Medical Sciences*, July, 1882, page 285.

A case of pyelitis; discharge of pus; incision in the loins; recovery. Reported by Dr. S. O. Habershon, at Clinical Society of London, Friday, January 23, 1880. *Medical Times and Gazette*, February 7, 1880, page 162.

920 MARKET STREET, SAN FRANCISCO, CAL.

A FEW PRACTICAL OBSERVATIONS UPON THE TREATMENT OF
THE LATE NEOPLASMS OF SYPHILIS.

BY

ALGERNON S. GARNETT, A.M., M.D.

THERE is no subject which has occasioned me more thought than the late neoplasms of syphilis, nor any which have shown a greater want of prescience in the treatment instituted for their relief. Their origin is often coincident with the second stage of syphilis, and under a temporizing treatment they have been evolutionized, until functional activity and organic integrity have been destroyed under their erosive power—the different types of paralysis being their product. With rare opportunities for seeing examples of the treatment pursued by the different medical men of this country, I am forced to the conviction that, with a few notable exceptions, the whole theory of the treatment of syphilis, particularly in its later stages, is somewhat erroneous; that remedial agents are not used to their higher potentialities, deference to authority halting the surgeon before he has made more than a fleeting impression upon the condition sought to be relieved, the fear of the remedies which he uses constituting one of the chief obstacles to successful treatment. The hypothetical procrustean bed in which every patient must be laid, with his allotted dose, is unscientific and absurd. Text-books for the guidance of the inexperienced should do away with *fixed maximum* doses, in chronic diseases, where opportunity for experimental tests are given, and the educated tolerance of remedies may become the measure of the quantity required. This tolerance may be reached without endangering life by

careful supervision. As illustrative of this statement, I have had the most brilliant results from the use of from six hundred to a thousand grains of potassium iodide daily, when an initial dose of five or ten grains, three times in twenty-four hours, was borne with the greatest discomfort. When the large dose is once attained, the irritation of the mucous membranes is much less than is often witnessed in the use of the smaller quantity. Affections of the kidneys, which have been frequently ascribed to the large doses of the iodides, have, so far as my observation goes, been due to the specific trouble, and coincident with other pathognomonic symptoms of that disease. I believe in removing neoplasms, whether slight or grave, and I consider no patient safe so long as there is the slightest evidence of disease present. I believe in stamping the disease out, and keeping it subjected, knowing how easily destructive processes develop grave proportions. As between too much medicine and treatment on the one hand, and syphilitic manifestations on the other, I choose the former always: few patients are overtreated, while thousands suffer from not having received treatment enough. The iodides and mercury should be pushed in the treatment of every stage of syphilis, and in as large doses as can be borne. If the cachexia of the later stages prevents the free use of mercury, tolerance of the drug must be cultivated until the patient can be put under the full influence—this being the only plan of safety. My own experience is so opposed to the partial relinquishment of mercury in the later stages of syphilis that I can hardly understand how many learned surgeons who have discussed this subject could have fallen into the grave error of confining their treatment chiefly to the iodides. Their perpetual use only, in large doses, would give protection. I do not believe that syphilis is a benign disease, nor that, in many cases, its tendency is to self-limitation. I question the statistics, in many instances, and doubt whether the supervision of the cases has been accurate which would point to such a result. The benignancy of to-day is formulated in the paralysis of to-morrow. The seeming health of a few years is brought to a final catastrophe by the horrors of dementia. In a case-book containing some ten thousand cases or more of syphilis, I might quote numbers which would prove interesting, but shall confine myself to one or two only:

E. D., æt. 32, a young man of healthy parentage, had contracted syphilis four years previous to the paralysis which brought him to me. After some unusual exposure on the West-

ern plains, he was stricken with paralysis, causing complete loss of power in the muscles of locomotion, as well as in the sphincters of the bladder and rectum. This condition had lasted for nearly a year when he came under my observation and care. To complicate the difficulty and render the case still more unpromising, he had a bad stomach which performed the processes of digestion very imperfectly. With watchful care, after three years of treatment, the patient was restored absolutely to all of his functions, and is now well and healthy, and in the active pursuit of business. This result was achieved by the administration of, in the aggregate, about two hundred thousand grains of the potassium iodide and the inunction of sixty ounces of mercury. Had I temporized with the treatment, by giving insufficient doses, I should have expected structural lesions of the cord to have ensued.

I. B., æt. 44, a miner, from Arizona, presented himself for treatment while affected with aphasia and mental imbecility, the result of syphilis contracted ten years previously. This case was treated for four years with large doses of the iodides [as much as eight hundred grains a day being given for a part of the time] and mercurial inunctions. This treatment was pursued interruptedly, the patient resting from all drugs for two months at a time. The result was extremely gratifying, as all of the symptoms were relieved and the patient restored to health and vigor. These patients were treated under the benign influence of the thermal baths of Hot Springs, for which I claim decided merit in the face of an adverse opinion entertained by some of my scientific friends. The action of these waters is reconstructive, stimulating and tonic, bringing into renewed activity energies that had long lain dormant. Chemical analysis shows that this water is undergoing constant changes, while losing its heat, by liberating gases and precipitating solids from the solutions in which they have been held, and, as from every chemical action electricity is evolved, this might account for the highly stimulating effects of these waters in contrast to water artificially heated. Practical results are the crucial tests by which we judge of the value of all remedies, all hygienic methods and treatments, and those agents are stamped as curative which achieve beneficent ends, however much in the dark we may be as to the how and why.

HOT SPRINGS, ARK., May 12, 1887.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

THE 173D REGULAR MEETING.

DR. ROBT. W. TAYLOR, *President, in the Chair.*

DR. JACKSON presented a case of

SMALL PUSTULAR SCROFULODERM.

The patient, Julia A——, æt. 15, has had the disease for two years, getting almost well in winter to grow worse again in summer. General health fair, though she is anæmic, has enlarged submaxillary glands, and rather strumous cast of features. One sister died of phthisis at nine years of age, with enlarged glands in neck. Location of lesions on hands, feet, face, scalp and upper portion of back.

Upon head has some pediculi. Lesions upon scalp are large discrete pustules such as are commonly seen in pediculosis.

Upon hands discrete pustules, small in size, which tend to umbilicate and leave small, rather deep, white, permanent scars. Ends of fingers are red and swollen, specially about the nail. She says the finger ends have always been "red and clubbed." Nails are badly formed, some of them striated longitudinally. Around nails the skin is ragged.

Upon feet same appearances as on hands, only more slightly marked.

Upon the back, between upper angle of scapulæ, are two symmetrical groups of pustules of the same nature as those on the hands.

Upon the face are a few small pustules forming lines on each side of the nose.

The peculiarities of the case are the locations of the lesions, and the scars left by them.

In discussing the case,

DR. BRONSON said he had had a case closely resembling that of Dr. Jackson. The lesion becomes a minute acuminate vesicle which lasts several months, followed by a superficial erosion. There is no infiltration, but a raised surface is presented, like that of a burn of the second degree. His case lasted six months and was followed by depressed cicatrices, which over the face and neck were permanent. He thought there had been fifty such cicatrices over the face. The lesions are itchy. The spreading erosion seems to begin in a follicle and may become as large as a finger nail.

DR. JACKSON said he had regarded the disease a scrofuloderm more from the family history than from anything else.

DR. FOX reported a case in which the lesions were quite similar. The patient was a young woman aged 24, of delicate appearance but without strumous symptoms. For three winters she had suffered from repeated outbreaks of papulo pustules upon the extremities. These lesions first appeared as firm, shotty, highly inflamed nodules, sometimes assuming a furunculous aspect. Soon they became flat and umbilicated, presenting a pale marginal ring and a central blackish crust. Ulceration often followed the violent removal of the crust, and the lesions healing always left some pigmentation and a pitted cicatrix.

There was a slight tendency of the lesions to appear in groups, but there were never any vesicles.

In the absence of other cases the President called for the recital of clinical histories and interesting cases, and hoped the discussion would be full.

DOUBLE CHANCRE OF THE NIPPLE.

DR. SHERWELL related the history of a double chancre of the nipple in an Italian woman from nursing an infected child belonging to another woman. The baby was the son of syphilitic parents, six months of age, and had a sore mouth and iritis. Three weeks after the woman began to nurse the child a chancre appeared upon each nipple. The woman was previously healthy and had large, well-filled breasts. Upon touching them the milk squirted out to some distance, and some entered the doctor's eye. He took precautions at once to prevent possible infection from any virus which might have been carried from the surface of the chancre by the milk.

The child was born with pemphigus upon the feet and buttocks.

DR. TAYLOR said that while the case was not unprecedented it was not common.

DR. KEYES said cases had been reported in which from seven to ten initial lesions had existed upon one or both breasts, and that Fournier had met with one case having nineteen separate lesions.

DR. ELLIOT reported a case of

DOUBLE ZOSTER.

The eruption had occurred in a man who had syphilis five years ago. It occupied both sides of the neck, extending to the median line on either side.

There had been most excessive pains through the whole body lasting for a week. He had given salicylic acid and iodide of potassium in ten-grain dose. There had been complete disappearance of the lesion but œdema of the tongue had come on and breathing was difficult. He had stopped the iodide and the œdema had disappeared. He had only taken one dose of the iodide, but said that the same trouble had previously been noted as due to the drug when being treated for the syphilis in Germany five years ago. At this time he had had to stop the iodide and take inunctions. There had been no syphilitic manifestations for three years. He did not regard the zoster as syphilitic. The lesions were in groups, circinate and infiltrated. The pustules and vesicles were not well formed but appeared partially aborted and indistinct.

DR. KEYES had seen a case in which, following an intense paroxysm of biliary colic, attended with fever, a double facial zoster or herpes, had appeared. The patches were an inch in diameter and covered the entire face on both sides, following the course of the two upper branches of the fifth nerve supply. In this patient there was constantly a fever attending his hepatic colic and herpes always followed it.

DR. TAYLOR said that Tilbury Fox had reported one or more cases about 1870, and that Kaposi had also recorded cases of double and relapsing herpes.

He called for the experience of the members in regard to these varied forms of herpes especially in reference to double zoster.

DR. SHERWELL recalled a case of herpes covering a large portion of the body which had followed a decided neuralgia. There was a general distribution upon both sides of the body following the major nerve trunks. He regarded it as a case of double zoster and thinks he has seen others.

In labial herpes and herpes febrilis the diagnosis presents no difficulties. He thinks, however, some forms merge into each other and are differentiated with difficulty.

DR. ELLIOT related a curious case which he was in doubt about calling a zoster. The patient was a man accustomed to hard work, who, after heavy lifting, had, upon the third day, upon both buttocks over the exit of the gluteal nerves an eruption of spots grouped together which became perfectly black. There was no pain. The lesions increased and twelve hours later he had on one buttock twenty-eight and upon the other twenty-five spots in size from that of a ten to a twenty-five cent piece. There was absolute gangrene, and upon lifting up the crusts showed exudation underneath. There was pain upon pressure over the last lumbar vertebra. He had been unable to find anything similar to this case in literature, but it appeared to be more closely allied to herpes zoster gangrenosus than to anything else.

DR. BRONSON said he had never seen a case of double zoster excepting one he saw in Professor Neumann's clinic in Vienna in 1871 or 1872.

DR. KEYES said he had seen at least two. They were both ordinary typical, straightforward cases of zoster confined to the trunk. He had shown both cases to the Bellevue Medical Class. Similar nerves were not involved on both sides of the trunk; upon one side the zoster being abdominal and upon the other thoracic. He thinks he has observed double zoster of the extremities as well.

DR. BRONSON asked how often the eruption was observed below the elbows and knees. He had seen a case the day before in which it extended to the tips of the fingers.

DR. FOX said he had also seen a case of double zoster at Neumann's clinic which the professor had at the time said was the fourth case on record. He had also observed cases of double ophthalmic zoster, unless attacks of herpes labialis or febrilis are seen occasionally upon the nose, eye-lids, etc. He showed a colored picture of one of Dr. Jackson's cases, in which the face was covered with an attack of double-sided herpes. He had seen herpes preputialis upon one side in connection with herpes of the lips. He thought that as these cases are extremely rare, when met with, all chance of doubt in the diagnosis should be removed by several competent men seeing the case together. In regard to Dr. Bronson's question, he had seen crural and brachial zoster extending down the leg and forearm. In the latter case to the fingers. Zoster of the extremities is comparatively rare, but when it occurs it is commonly seen to extend the whole length of the nerves. He referred to the case of Dr. Gibney, in which the eruption extended the whole length of the arm and forearm, and down upon two fingers, upon the lateral surfaces, but not upon the palms. The case was followed by paralysis of the limb, and at the time thought it made a unique case in the history of zoster, but he has since read of a similar case. This case was caused by a fall. He has since carefully examined all cases as to a causative injury, and has been surprised to find how often a fall or some injury could be discovered as the probable origin of the lesion. He had seen two or three cases of zoster frontalis involving the face and neck, in nearly all of which an injury was reported, and looked upon as the origin of the trouble. One patient had spent from half to three-quarters of an hour in a caisson of the new Harlem bridge, and had then experienced pain in the right ear, which was followed by a well-marked zoster upon the neck, cheek and about the eye. He had also seen a case where a blow upon the head of a woman had been followed in four or five days by a profuse eruption of vesicles over the region supplied by the supra-orbital nerve, which nerve he thought had been injured by the blow. He questioned whether local treatment does much good, and whether internal treatment does anything to abate the course of the disease. He has seen no good effects from any

internal remedy. He has, however, seen the eruption repeatedly abort after twenty-four hours. He had, in individual cases, seen apparently beneficial effects from rhus, phosphite of zinc and other remedies, but when tried again they would fail, and he had considered that the case in which a remedy appeared to cut short the disease was one that would abort of itself.

Electricity, however, had always given favorable results in his hands, relieving the neuralgia for an hour the first day, and giving relief for half a day the next time applied. He had used the galvanic current both descending and ascending, usually with the negative pole below. He has seen relief from a single application (after the patient had spent one or two sleepless nights. He applied usually the sponges or roller electrode around the patches. Electricity is the only mode of treatment he can recommend strongly. Galvanism cuts short the disease. He has used collodion over the patches of vesicles, but has not had good reports from patients.

DR. KEYES said his sole treatment for a case of zoster of the trunk consisted in applying collodion (flexile) to the vesicles before they were ruptured, and dusting the surface with a dusting powder after they had broken, and applying electricity. This treatment keeps down the vesicles and prevents their maturing.

DR. SHERWELL mentioned a case in which there had been iritis from zoster of the ala of the nose.

DR. BRONSON spoke of the coincidence of zoster and paralysis. He had seen two cases in which the third branch of the trigeminus had been affected. Where the sensory and motor nerves are distinct, as in the nerves of the cranium, it is difficult to explain these cases.

Counter irritation, as by galvanism over the origin of the affected roots, has in one case of his caused pain to disappear within half an hour.

DR. PIFFARD stated that he had never seen a case of double zoster. As regarded anomalies in herpes he had observed a case of persistent pruritus following zoster, which had lasted for several years and was not at all benefited by electricity. Another case was followed by neuralgic pains which lasted for several years. Here also electricity did no good. He prefers as a local treatment the application of a sedative, and for this purpose employs the fluid extract of belladonna, which he paints thickly over the affected side and over this applies collodion. The vesicles should be prevented from rupturing if possible. He had used electricity extensively, both the constant and interrupted current, and had come to the conclusion that it did no good. He had found the best results to follow the application of the Paquelin Cautey over the nerve ganglion when it could be reached, and over the posterior root when one of the spinal nerves was affected.

DR. MORROW said he did not remember ever having met with a case of double zoster. It is a very unusual condition. Most text writers say that zoster does not occur below the knee. He, however, had had a case several years ago, in the person of a lawyer who had two patches, one as large as a silver dollar and one twice this size over the middle portion of the abdomen. There had been a pain in the knee before this eruption of herpes upon the abdomen. The eruption in this case appeared upon the thigh and leg and extended upon the foot to the end of the great toe; three well-marked vesicles appearing on the extreme end of the toe. He called attention to this rare development of zoster in connection with a zoster following the course of the nerves of the trunk. The pain was relieved by hypodermic injections of morphine. There was no eruption upon the planter aspect of the foot aside from that on what was really the under surface of the toe.

He had seen herpes preputialis in connection with patches of herpes around the anus upon the opposite side of the body. He had never thought that treatment should be otherwise directed than to the relief of subjective symptoms. The pain is usually very intense preceding the eruption and almost always disappears after it. For the past three or four years he has

used a preparation termed benzoated collodion and had found that it not only served as an admirable protective dressing, but seemed to prevent vesicles forming upon the erythematous patches which first appeared. In almost all cases in which the collodion is properly applied it will prevent further eruption upon the patches. The most annoying features of zoster are the after results. In one case seen in a patient over sixty years of age the pain had persisted for weeks and months. One case of zoster under the scapula in which the pain was persistent and always worse at night, and in which oil of peppermint, menthol, and similar drugs had been used without any effect, hot water bags upon which the patient rested the painful part, gave almost immediate and permanent relief. He had used a variety of internal remedies in the treatment of zoster, but never discovered any great good in any of them. Electricity had given only negative results.

DR. CAMPBELL said he had seen a double abdominal zoster in a woman of forty-five or fifty years of age several years ago at the Demilt Dispensary. He has also seen a zoster extend down the back of the arm and hand and over the fingers. In his double zoster case the same nerves were affected on both sides.

DR. STURGIS said he had never seen a complete double zoster, but had seen an abdominal zoster of one and a gluteal of the opposite side. He had had too little experience with electricity to speak of it, but had thought benefit had at times been derived from the use of arsenic and aconite. The latter drug he spoke favorably of in the neuralgic pain. His main treatment is protection of the vesicles and dusting with zinc oxide. It is a self-limited disease.

He had seen several cases in which rheumatic pains developed in other parts of the body than those affected with herpes.

DR. LEWIS did not remember ever having seen a case of double zoster. He has found the best application to be white lead paint, to which an extra amount of drier has been added in order to cause it to harden quickly. He does not use any internal treatment, for he never saw it have any beneficial effect. He has usually found the pain severe before the eruption of vesicles, and has directed treatment toward its relief.

DR. TAYLOR had seen two cases of double zoster in 1872. He related the case of a patient who presented three gangrenous spots running around the body at the level of the twelfth dorsal vertebra. They were gangrenous, foul smelling and had a blackish surface. Dusting with iodoform cured the lesions and eased the pain. The condition had been taken for lupus, syphilis, etc., but was in reality a case of zoster gangrenosa. He related also the history of a case of zoster of the leg in a lady otherwise perfectly healthy, whose only bad habit was the nightly indulgence in lager beer. After family trouble, pains of a neuralgic nature began to be noticed in one leg, followed by a zoster. When her troubles were at an end she promptly recovered.

He had seen zoster of the arm following the brachial plexus, run down the hand and be followed by atrophy of the biceps muscle. Trauma, cold, etc., are accused of acting as causative agents. He has also seen a zoster of the gluteal region accompany a zoster preputialis, and had observed two attacks of zoster nasalis.

DR. BULKLEY had also seen the case of double zoster mentioned by Dr. Campbell.

DR. SHERWELL spoke of the singular fact that the vesicles did not usually occur upon the palmar or plantar surfaces.

DR. ALLEN had never seen a double zoster. He had, however, seen zoster of the arm twice extend beyond the elbow, once to the wrist and once down upon the hand.

He had expected to present a patient at the meeting who showed very beautifully how the eruption at times extended upon the foot. The patient had come to him the day before with the following history: Agnes W—, age 30,

had always been well. Two weeks ago a severe pain began in the left hip, and soon extended to the foot, preventing sleep. This continued until five days ago, when an eruption of vesicles appeared on the thigh and leg, and the pain ceased. The vesicles are situated upon the inner surface of the left thigh, surround and spread out below the knee and extending down the lateral and posterior aspects of the leg and in some small groups upon the dorsum of the foot. The vesicles are tense and upon the thigh and leg are, for the most part, closely packed together in circular patches, situated upon an erythematous surface. Below the knee the eruption is of a bullous nature and the lesions are scattered, but in all situations follow the course of the nerve supply.

His treatment had always been directed to the protection of the vesicles, and he had been much pleased with the benzoinated collodion, using it in all such cases in preference to the simple flexile collodion.

He had once seen in a drunkard an eruption of boils, which simulated a zoster in its distribution over the back and abdomen. There was no history of a vesicular eruption, and no signs of one at the time the case was seen.

DR. BULKLEY asked if zoster had been prevalent of late.

DR. ALLEN said he had seen a number of cases recently, and thought it more common than usual.

DR. ELLIOT said he had seen seven cases during the past month.

AMERICAN DERMATOLOGICAL ASSOCIATION.

THE annual meeting of the American Dermatological Association will take place on August 31st and September 1st and 2d at Baltimore in the hall of the State Medical and Chirurgical Society. Dr. Piffard will preside and the following are the titles and writers of papers which have been sent in to date:

1. Salt in Dermal Hygiene and Therapeutics. H. G. Piffard.
2. Chronic Inflammation and Infiltration of the External Genitals of the Female. R. W. Taylor.
3. A Clinical Study of Erysipelas in Infants. J. E. Atkinson.
4. Leucopathia Unguinum : a Peculiar Affection of the Nails. R. B. Morison.
5. Notes on Treatment in Ordinary Skin Troubles. R. B. Morison.
6. Protest Against Excessive Strength of Local Applications (official and other) in Skin Diseases. S. Sherwell.
7. Clinical Notes on Pruritus. L. D. Bulkley.
8. Clinical Notes on Pediculosis. F. B. Greenough.
9. On the Use of Medicated Rubber Plasters in Certain Cutaneous Diseases. H. W. Stelwagon.
10. A Case of Purpura with Circinate Lesions. H. W. Stelwagon.

G. H. TILDEN, *Secretary*.

EXTROVERSION OF THE BLADDER.—Dr. Zesas records in the *Centralblatt für Chirurgie*, No. 8, 1887, a successful case of operation for this deformity by the method proposed in 1882 by Professor Sonnenburg. The operation consists in removing the bladder entirely, fixing the ureters into the fissured penis by sutures, and covering the opening left in the abdominal wall by a skin-flap operation.

At the Eleventh Congress of German Surgeons in Berlin, Sonnenburg presented a patient who had undergone the operation, but only a few other cases have been recorded.

Selections.

SALPINGITIS GONORRHOICA ET SYPHILITICA.

IN a communication from Dr. M. Sanger, of Leipsic, read before the Chicago Gynecological Society and published in *The Obstetric Gazette*, February, 1887, he says:

“Salpingitis gonorrhoeica is the only specific infectious form of salpingitis which is recognized as such by Lawson Tait, although he stops short of admitting that the gonococcus is the exciting agent. Without doubt the gonorrhoeal is the form most frequently met with. This fact was clinically established as early as 1872 by Noeggerath, long before Neisser had discovered his gonococci or Lawson Tait had performed his first operations ‘for suppuration of the uterine appendages.’ In Germany, I myself was one of the first gynecologists who at our meetings showed the frequency of gonorrhoeal salpingitis, emphasized its casual connection with pelveoperitonitis, and removed by operation the gravely implicated uterine adnexa. (Magdeburg, 1884, and Munich, 1886.) Gonorrhoeal salpingitis is never followed by a destructive ‘suppuration’ of the uterine appendages:—it remains invariably a disease of the surfaces of the mucous and serous membranes. The pus formed by the specifically diseased mucous membrane gradually distends the tube; in one class of cases in which there is a great accumulation of free pus the tube is transformed into a large sac with thin walls; in another in which the wall of the tube, especially its muscular tissue, is hypertrophied to a greater extent, the tube becomes much thickened and rigid. In most cases, both conditions are found, the uterine portion of the tube is thickened, the abdominal end dilated. The serous surfaces of the tubes, the albuginea of the ovaries, the serosa of the peritoneum are attacked or become pus-secreting surfaces only in cases in which gonorrhoeal pus has escaped from the tubes and thus infected the above named structures. We may then have peri-salpingitis, peri-oöphoritis, peri-metritis, s. *pelveo-peritonitis purulenta gonorrhoeica*. I do not believe that gonorrhoeal pus ever penetrates the walls of the tubes and thus produces these diseases. But a specific gonorrhoeal inflammation of the mucous membrane of the tube, with secretion of pus into the cavity of the latter, is accompanied by a non-specific inflammation of the entire tubal wall. This may also excite peri-salpingitis, peri-oöphoritis and so forth; the organs involved may become adherent to each other and displaced, but we never meet with a purulent exudate of the same nature as that found in the cavity of the tube itself. This also explains why, in some instances, gonorrhoeal disease of the uterine appendages is accompanied by severe and violent symptoms, frequently resembling those of a peritonitis following perforation, whereas in other instances it develops insidiously, scarcely manifesting any symptoms at all. In the former cases, gonorrhoeal pus escapes through the *ostium abdominale* into the peritoneal cavity; in the latter the inflammation of the external surfaces of the adnexa is non-specific in character.

“I purposely enlarged somewhat on gonorrhoeal salpingitis and its consequences, as this form presents a typical example of infectious salpingitis in general.

“There is one more point to which I wish to call attention. Gonococci have not always been discovered in pus coming from the tubes in cases in

which clinically there existed no doubt as to the gonorrhœal nature of the infection. The conditions under which the gonococci are destroyed, or prevented from further development, have not yet been ascertained; further investigations will also have to show whether, in cases in which gonococci are absent, there are not present other microbes.

"Occasionally we find in young girls, who have never had intercourse with a man, tubes filled with pus, and pelveo-peritonitis. This has been accounted for in various ways. It has been said that in these cases a serous catarrh is intensified and changed to a purulent inflammation; that the suppuration is due to catching cold at the menstrual period, or to a trauma. These cases have also been adduced as evidence to show "that tubal suppuration is not always of gonorrhœal origin." Yet also in these cases there is always an infection, and usually a gonorrhœal infection. I, myself, have seen a comparatively large number of girls of all ages, from infancy to puberty, who were infected with gonorrhœa. We know how easily the infecting germs are carried from one person to another; for instance, parents and children may use the same sponge or bath tub; the germs may adhere to fingers, linen, etc. The girls infected may further spread the disease in school, and so on.

"*Salpingitis syphilitica*.—This form has been described by Bouchard and Lépine (*Gazette Med. de Paris*, 1866, No. 41). Both tubes were swelled to the thickness of fingers, and contained three gummata of the size of hazel nuts. The description given by these authors of the tubal disease agrees fully with the changes brought about by syphilis in other organs. Of more recent authors, Gill Wylie expresses his opinion that tubal syphilis does occur. ("Diseases of the Fallopian Tubes," etc., January 24th and February 7th, *The Medical Record*, 1885). He says that "syphilis may cause salpingitis, just as it does otitis or ozæna." He also calls attention to the fact that "endometritis in syphilitic subjects has a most obstinate character." Compared with the actual observation of Bouchard and Lépine, the clinical remarks of Gill Wylie, are, of course, of theoretical value only.

"Like Lawson Tait, I, myself, have never yet had occasion to observe an undoubted case of tubal syphilis. We should bear in mind, however, that our attention has been but little called to the anatomy and clinical forms of this disease. We are not justified in denying this form altogether, as we are not in a position to dispute the reliable authors who have testified to its existence. Others may have seen what we ourselves have never had occasion to witness. I desire to give a most complete enumeration of the forms of infectious salpingitis hitherto described; I could as little have omitted *salpingitis syphilitica* as I could *salpingitis actinomycotica*, of which also up to date but one authentic case has been observed."

THE EVOLUTION OF SYPHILIS IN PATIENTS AFFECTED WITH ALBUMINURIA.

THIS question has scarcely as yet been studied, except in isolated observations. Dr. Raval has just collected in his thesis a number of facts, demonstrating what might be supposed *à priori*; that is to say, that albuminuria constitutes an important factor in the development of syphilis. In the observation made from the beginning of the disease, the eruptions were seen to be more intense, and were not disseminated over the surface of the

body, but very thickly set, sometimes even confluent to such an extent as to form large blotches. Their form was much modified, so as to resemble ordinary dermatoses. It will be remembered that these characteristics are not common in light cases of syphilis, but are rather the accompaniment of grave cases. It is usual, in fact, to see cases of syphilis beginning in this way become tenacious and persistent, giving rise to repeated manifestations, following each other in quick succession. This is what is observed in the cases of patients where the disease is always in activity. Later on the malignant nature of the disease is manifested by other characteristics. At an early stage of its evolution, serious lesions of the skin and mucous membranes were developed, the nervous system was attacked, and the disease resisted specific treatment. Ecthyma, pemphigus, and rupia showed themselves in a very precocious fashion. The resistance of the disease to treatment was very remarkable, and its importance is well worth examination.

Authors, in fact, do not agree as to the advisability of a mercurial treatment in cases where the patients are affected with albuminuria. It had been said that mercury produces albuminuria, and that the albuminuria is intensified by its use where it already exists. However, it appears, from researches made by Professor Fournier and by Dr. Grilleton, of Lyons, that, among all the patients in their wards submitted to a mercurial treatment, not a trace of albumen was found in any of them. This fact might indicate that the harmlessness of a mercurial treatment can be accepted without further examination, in cases of albuminuria. Moreover, in all the cases cited by Dr. Raval, mercury does not appear to have augmented the albuminuria, or even to have in any way interfered with the action of the treatment directed toward the renal accidents. It appears necessary, also, to administer the specific treatment at the beginning of the accidents, but there is one condition that must not be overlooked, and that is to watch attentively the elimination of the mercury, and to suspend its use as soon as salivation appears, or as soon as any other symptom announces its accumulation. Any preparation of mercury may be exhibited, provided it is tolerated by the patient.

In a certain number of cases also a mixed treatment was followed; that is to say, the patient took, at the same time, both mercury and iodide of potassium. The latter medicine seemed also to have been well tolerated. Nevertheless, its action should be watched and, as far as possible, at the same time a lacteal diet should be prescribed.—*Paris Correspondence American Lancet.*

METHODS OF TREATMENT OF PROSTATITIS, WITH ESPECIAL REFERENCE TO HYPERTROPHY OF THE PROSTATE.

AMONG the different forms of prostatitis, Dr. Fischer of Munich (*Centralblatt für Chirurgie*, No. 3, 1887) distinguishes that of youth, in which the genitals are overused (*i. e.*, misused) from that of older individuals. The first always appears as an acute affection, and at times violent in its onset, with high fever, rigors, and even sopor, until the abscess in the urethra bursts, either spontaneously or from attempts at catheterization. Its cyclical course lasts about eight days, and repeats itself after a time. Often for many years one attack follows another in the same way, and finally ends in a cure. Occasionally, however, it passes into a chronic inflammation, with hypertrophy. The more chronic form in older people begins usually with catarrh

of the gland, prostatorrhœa, and leads slowly to hypertrophy. According to Nussbaum, it is very characteristic of the affection that when the catheter can not be used, the bladder may only be emptied when the body is placed in a peculiar position, and indeed the position of the body which renders this possible, does not remain the same, but must be changed from time to time to effect the same result. We pass over here the well-known resulting conditions, and point out only the not infrequent occurrence of abscesses. During the treatment of prostatitis in its acute stage, after the regular course of treatment and along with the ordinary after-treatment with iodine and bromine mineral waters, Nussbaum has used the cold ascending douche with great success; a treatment which, in chronic prostatitis and hypertrophy of the prostate, even in cases of long standing, is followed by the best results. Occasionally, among the better class of patients, this treatment may be advantageously combined with brine and sea baths either as full or sitz baths. He disapproves of all methods of treatment which have for their object the forcible dilatation of the narrowed portion of the urethra or the destruction of the gland, as well as all operations for extirpating the prostate through the rectum. Bottini's galvano-caustic treatment is, on the other hand, approved by Nussbaum, although the difficulties of the operation do not favor its employment. Notwithstanding the untoward results of parenchymatous iodine injections, Iverson's sub-cutaneous injections of ergotine are thought to deserve careful attention. It is not advised to make an opening of a prostatic abscess from the urethra because of the danger of making a false passage in catheterizing. The incision through the rectum or the perinæum deserves also the preference over puncture with a trocar. Maas's recommendation to divide the sphincter ani in severe cases is worthy of attention because of the opportunity thus given of applying antiseptic washes.

When there is retention of urine in consequence of hypertrophy of the prostate and the various methods of catheterization have been tried without success, the author recommends, according to Nussbaum's method, the puncture above the symphysis pubis, with the subsequent introduction of a Nélaton's catheter, and with antiseptic washing out in preference to the puncture for aspiration, in which latter washing out is not possible—a very important procedure, and one which ought frequently to be done. According to the author's observations, he has often succeeded, directly after the first operation, in introducing the catheter through the urethra; when, after the cure of the cystitis and the removal of the resulting inflammatory products, the prostate rapidly decreases in size, and the fistulæ are also soon cured.

IODOFORM INJECTION IN CYSTITIS.

PROFESSOR CHANDELUX recommends (*Lyon Médical*, June 5, 1887,) in certain cases of rebellious cystitis, an intra-vesical injection of an ethereal solution of iodoform. For this purpose he employs an almost saturated solution, or one containing 13 grains in each 100 grains of ether.

He has obtained very favorable results in painful cystitis of tubercular origin, and in other cases of long standing, in which urination took place as often as ninety-six times in the twenty-four hours.

Chronic cystitis often produces a decided thickening of the bladder walls, and by their contraction the capacity diminishes greatly. If now we attempt to distend the cavity by a tepid injection of boracic acid solution

very severe pains are soon produced, the bladder revolts and the liquid is forced out between the sound and the walls of the canal.

In a word, the vesical reservoir loses its power to bear a distension of its walls.

In employing injections of iodoformed ether, the bladder having previously been emptied by the patient, the distension is seen to take place with a certain degree of ease. According to the author's opinion there is an exact balance established between the expansive force of the vapors of the ether and the power of tolerance in the bladder walls, and it is this which constitutes the great superiority of this over all other injections. An evident proof of this distension is furnished by the vesicular tympanites, which is revealed by percussion over the pubes. The capacity of the bladder can be thus shown as well as by the amount of liquid retained, to increase gradually from day to day. The rôle played by the iodoform is considered only secondary by the author, who says that it is all rapidly washed out by the urine and never deposited upon the walls as concretions, which might afterward become the origin of calculi. The first injections are usually attended with considerable pain.

VITILIGO SYPHILITICA.

DR. POELCHEN (*Virchow's Archiv*, Bd. CVII., p. 535) has given the above name to certain white patches, free from pigment, which appear upon the pigmented skin of patients who have gone through a macular syphilitic eruption. The condition is more commonly observed in women, and affects chiefly the neck. The following conclusions are drawn by the author :

1. Following closely upon a syphilitic roseola, a deficiency of pigment is found at the site of the roseola patches.

2. The patches, from their form and distribution, are to be regarded as a positive diagnostic sign of syphilis.

3. The duration of the condition varies from a few days to about four years.

4. To the condition of vitiligo belongs a roseola upon a pigmented skin.

5. The white spots disappear of themselves, and most rapidly if the skin is exposed to the direct action of the sun.

Dr. Fisson, in an interesting and conscientious study of dyschromæas of the neck, presented at the Paris Academy de Médecine, June 21, 1887, also considers cervical pigmentary syphilide as a "Syphilitic Vitiligo," and believes it to be, in all likelihood, of nervous origin.

He further believes that the degree of coloration of this syphilide is often in direct relation with the gravity of the diathesis.

LA SLETTE MILIAIRE.

An epidemic of the sweating sickness has recently attained alarming proportions in the departments of Vienne, Haute-Vienne and other parts of France. The mortality from this disease, which appears to be an idiopathic miliary fever, has in former years been enormous, and at the present time would appear to have a mortality of from eight per cent. in some localities to thirty-three per cent. in others. Four thousand cases and three hundred deaths are reported from the Montmorillon district alone. As long ago as 1485 an epidemic occurred and became historical under the name of *Slette Anglaise*. The *British Medical Journal* of July 2d, says that it raged in London in that year and also in 1499, so that Henry VII. and his court

removed to Calais. In 1506-1507 there was a terrible epidemic and Oxford was depopulated. Several epidemics have occurred in France during the present century, and have been preceded, as in the present instance, by many cases of eruptive diseases mistaken for the measles. The patients have a profuse perspiration and an eruption in some cases resembling measles, in others scarlatina, but always *vesicular*. Upon the tongue the vesicles produce ulcers. There is usually no prostration and little loss of appetite, but in some cases the worst symptoms of a malignant fever are present. It is believed to be infectious.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

Trichophytosis Corporis.

DR. E. BESNIER recently exhibited at one of his clinics at the Hôpital St. Louis, a child five or six years of age, whose face was covered with a large red patch, involving the nose, half the right cheek, about a quarter of the left cheek, both right eyelids, half the left eyelids, and the lower half of the forehead. The edges of the patch were sharply defined, and a little prominent. Its surface was pale red, and covered with furfuraceous scales. Eczema could be excluded from the well-marked borders, and from the entire absence of exudation. In fact, at first sight it looked most like an erythematous lupus. But a careful examination of its periphery showed that it was covered with minute rounded crusts disposed in lines and side by side; apparently they were the dried contents of pre-existing vesicle. The affection had only existed one month, and upon the child's neck was a characteristic patch of herpes circinatus. There could be no doubt as to the diagnosis. It was a case of trichophytosis corporis of the face of uncommon extent and in an unusual situation. The child had been for some time in the habit of playing with a young calf which was suffering from the same affection. Besnier remarked that children showed a great predisposition for the reception of ring-worm even of the skin, and that the trichophyton grew with much greater facility in their tegumentary structures than in those of adults. Nor do we ever see in the latter trichophytosis of the hairy scalp, so common among those of tender years. If we desire to find the parasite in ring-worm of the body we must search for it not in the scales, but in the small hairs at the margins of the patch. Treatment is a very simple matter, and it is hard to understand why we continually experiment with new therapeutic measures when we have long known in the tincture of iodine a practical and very efficacious remedy for herpes circinatus. As a rule, all that is necessary is to apply the tincture with vigorous friction to the entire patch in order to obtain a complete cure. On the face, and upon delicate regions like the eyelids, we cannot use such vigorous measures. We may then make two or three applications of tincture of iodine at intervals of two or three days. The following method is one which has been employed by Dr. E. Vidal in a case of cutaneous trichophytosis: Make an application of tincture of iodine every morning for three days to the diseased

skin, and let it extend over on to the healthy tissue; on the fourth day omit it, and make a last application upon the fifth day. This is certain to effect a cure.

It is very different, however, when the trichophyton tonsurans attains its greatest development in the scalps of children and the beards of adult men. In the one case it constitutes tinea tonsurans, in the other parasitic sycosis; obstinate affections, against which, in France at least, as I told you in a preceding letter, topical applications alone are useless. We are obliged to practice epilation, especially around the affected areas to arrest the progress of the parasite. That done, we employ all the well-known parasiticide remedies, from Van Swieten's liquid to oleate of mercury and the medicated collodions. We reject Croton oil alone, believing in the Hospital St. Louis, of Paris, that there is danger of its causing permanent alopecia, which the trichophyton itself never does when left alone.

Alopecia Areata and the Schools.

It is needless to say that all the physicians in France are in accord in prohibiting patients suffering from trichophytosis from attending the public schools; but the same is not the case with alopecia areata. Dr. Ollivier read a paper before the Paris Academy of Medicine on February 8, 1887, in which he attempted to demonstrate that alopecia is always of nervous origin, that we have no reason at all to consider it contagious, and that children suffering from it should be permitted to go to school. In a recent article in the *Bulletin Médical*, Dr. E. Gaucher upholds the same theory. I think for my part that we have as yet no certainty upon the subject; but that according to certain observations of Hardy, Lailler, E. Vidal and E. Besnier, it seems that some cases of alopecia at least are transmissible from the sick to the well. It is very probable that the group alopecia contains affections of various natures, and of different origins, which we cannot as yet distinguish objectively. Some may be trophoneuroses, and non-contagious, whilst others appear to be transmissible and are doubtless caused by some vegetable parasite or microbe as yet undiscovered. In so far as the progress of bacteriology has enabled us to elucidate this obscure point, together with the clinical facts pointing to contagion in certain cases of alopecia, it would seem well to reserve our opinion; and, not being able to distinguish contagious alopecia from trophoneurotic alopecia, we should forbid the attendance at our public schools of any children suffering from the affection.

The Treatment of Impetigo.

The researches of various authors several years ago proved that impetigo was a contagious and inoculable affection, but we have not yet by any means elucidated all the problems involved in its etiology. How, for instance, can we explain the appearance of pustules of impetigo upon the face after excess at table or great fatigue in gouty subjects who perhaps have patches of ecthyma upon other parts of their bodies? Is it possible that a microbe, inoffensive under ordinary conditions of the organism, can become pathogenic in lymphatic subjects when they are exposed to certain morbid conditions? One thing is certain: the affection once developed upon an individual can multiply upon him by auto-inoculation, and can be transferred by inoculation to healthy persons; hence the well-known epi-

demies of every-day occurrence, affecting a village, a school, a house, a family. Hence the necessity of an antiparasiticide treatment. E. Vidal proceeds as follows : He first removes the crusts which cover the affected parts by poultices, and then rubs in an antiseptic solution, usually baryta water or dilute camphorated brandy. Then he applies to each impetiginous pustule a small piece of the following plaster which Vidal calls "red plaster" : *Emplastrum diachylon* 27 grammes, *cinnabar* 1.5 grammes, *minium* 2.5 grammes, m. spread on fine muslin. These plasters should be changed every day, and the affected parts are to be washed with the antiseptic solution at each renewal. E. Besnier employs the following very similar method : The crusts are removed and the surfaces washed with borated water (1 in 50). Then they are covered with a mask of *tarlatan* eight or ten times folded which has been steeped in borated water. The whole is then covered with a layer of sheet rubber. This mask is to be removed hourly. When the inflammation has subsided we can use lotions of borated water to which a little sublimate has been added. Then Besnier uses an agglutinative plaster of which the following is the formula : *Unguentum de Vigo*, 5 grammes; *vaseline*, 30 grammes; *boracic acid*, 1 gramme, m. Spread thinly upon very fine linen.

The Treatment of Rosacea.

The same dermatologist pursues the following treatment in cases of *acne rosacea*: 1°. Entire prohibition of alcohol and wine, and I would add with my teacher Vidal, of coffee, of spiced or salted meats, of shellfish, crustacea—in fact of all aliment which, being difficult of digestion, is liable to cause congestion of the face. 2°. The use of purgatives, diuretics and sudorifics to act upon the intestinal, renal and cutaneous functions and thus to facilitate the elimination of the hurtful products which have been formed within the organism. 3°. The avoidance of external irritants such as cold, strong winds, or hot fires, which might congest the face. 4°. The use of topical irritants at the points affected. In mild cases it suffices to apply on going to bed a mixture composed of equal parts of soap and precipitated sulphur. This is to be removed in the morning, and the application is to be continued each night so long as the patient can bear it. When the inflammatory reaction becomes too active, an emollient ointment, or cataplasms of potato flour are to be used, and the treatment recommenced. When the *rosacea* is but very slight, a thin coating of the following preparation may be applied to the face at night: precipitated sulphur, 50 grammes; glycerine, 30 grammes; camphorated alcohol, 80 grammes. Rose water may be added if desirable. Vidal employs a sulphur lotion composed of: camphorated alcohol and precipitated sulphur, 30 grammes; distilled water, 250 grammes; to be applied to the affected parts in the evening, and to be removed with very hot water in the morning. An excellent modification of this method consists in using frictions of hot water and green soap in the evening before making the application, and using them in the morning to remove it. It is also advisable to use zinc oxide ointment upon the parts during the day. I have thus succeeded in doing considerable benefit to very obstinate cases. 5°. Finally Besnier sometimes prescribes internal medicines for the relief of the vascular dilatation of the face. He uses chiefly *hamamelis* and *ergotine* for this purpose. It is undeniable that it is above all necessary to discover the cause of the affection and to attack the evil at its root. Therefore when I am called upon to treat a case of *acne* or *rosacea* I consider it indispensable to make a complete ex-

amination of the patient, to explore all the organs, to see to the *prima via*, to regulate his dress, to pay attention to the circulation in his lower extremities, and to treat with the most minute care any affection of the genito-urinary organs which may be present. I do not hesitate to modify my patient's constitution if it be necessary, and, according to the case, to prescribe cod-liver oil, arsenic, or alkalies.

Treatment of Seborrhœa of the Head and of the Face.

The same therapeutic principles are applicable to the treatment of seborrhœa, an affection for which the sulphur preparations are very applicable. In the male, E. Besnier has the hair cut as short as possible, and directs them to remove as much as they can of the seborrhœal matter by means of hot water and soap. If there is seborrhœa oleosa the application should be done in the evening as well, and then the part be powdered with the following: Salicylate of bismuth 5-10 grammes; powdered starch 95-90 grammes. For seborrhœa sicca, on the other hand, there should be rubbed into the scalp every evening an ointment of naphthol, resorcin, sulphur or salicylic acid, followed in the morning by soap frictions.

The same remedies are to be used for seborrhœa of the face. If it is obstinate, and not too extensive, it may be modified, or even made to entirely disappear by doing linear scarification over the affected area. Vidal and Besnier have thus cured in fifteen to forty sittings at five to eight days interval rebellious cases of this kind of the nose and face. We know also that linear scarification is an excellent treatment for rosacea.

For cases of obstinate seborrhœa of the eyelids Besnier employs vigorous frictions every morning with a brush and a soft potash soap. Every evening an ointment containing 5 to 20 % of B-naphthol, or one of oil of Cade, or, best of all, an oil composed of equal parts of cod-liver oil and oil of Cade is to be used. It does not matter if the hair of the eyebrows falls out from these frictions; in fact, it is well to remove them as they appear. They will, in time, grow with all their former vigor.

Treatment of Furunculosis.

According to Dr. Palasne, of Champeaux, the use of the iodide of iron favors the resolution of furuncles, hastens maturation when they are already present, and even prevents their appearance. It acts as a microbicide, being eliminated by the glands of the skin and destroying the pathogenic microbe of the affection. He usually prescribes Blanchard's pills of the iodide of iron two to four a day (that is to say 10-20 centigrammes of the iodide of iron), and he continues their administration for at least eight days after the last furuncle has disappeared. As the iodide of iron is a very unstable compound, we may have recourse to the following process: Take in a glass of water a teaspoonful of preparation No. 1: Powdered sugar, 40 grammes, iodized alcohol, 40 drops (mix rapidly, and put into a well-corked bottle). Then take immediately a packet of No. 2: Iron by hydrogen, 8 centigrammes, sugar q.s. Without reflecting in any way upon the results published by Palasne, we desire to inform our readers that we have had no personal experience at all as regards the efficacy of this method. The remedies which in our hands have been of the greatest value in cases of furunculosis have been: 1°, internally, the sulphides, and agents directed towards the general condition of the body. 2°, locally, care of the skin, lotions of cam-

phorated alcohol and aqueous sublimate solutions, and finally, applications of red plaster or emplastrum de vigo.

Lupus Complicated with Epithelioma.

I have to record the appearance of two important articles upon this subject. One is the thesis of Dr. Bidault, pupil of Prof. H. Leloir, of Lille; and the other is a memoir by Raymond, an interne of Dr. E. Vidal. They contain clinical observations and original histological examinations, and form a complete statement of our present knowledge of this subject. There is but little further to say in regard to treatment. If the epithelioma is of small extent, and sufficiently superficial, it will suffice to follow Vidal's process. After a preliminary curetting, powdered chlorate of potash is to be applied in substance, or compresses steeped in a concentrated solution of the drug are to be laid upon the part. If the new growth is more extensive or deeper, it is not amenable to medicinal treatment, and we must have recourse to ablation.

Mutilating Syphilis.

As soon as the discussion, which is at this moment taking place in the Société Médicale des Hôpitaux, will have ended, I shall have something to say in regard to the opinions which are held in France regarding the new treatment of syphilis by injections of calomel and the yellow oxide of mercury. I have already written to you something about it. To-day I desire to call your attention to a point upon which E. Besnier has strongly insisted in his last clinical lectures. It is in regard to syphilis mutilans. He claims that syphilis is a mutilating affection of the first rank. It destroys, especially when untreated, not only the nose, the soft palate, and the nostrils, but also the extremities, the hands and feet. He showed us splendid original drawings showing the hands of a woman who was supposed to be suffering from a variety of lepra mutilans, and in whom the active ulcerations were rapidly cured by mixed treatment; unfortunately she had already lost several phalanges. When I took E. Besnier's place in the Hospital St. Louis last year, there was a young girl suffering from hereditary syphilis. Among other morbid manifestations she had ulcerative lesions of the fingers, which had led to the loss of several phalanges. It is of the greatest practical importance to appreciate these facts; for, as Besnier has remarked, syphilis mutilans is not malignant syphilis. It is neglected syphilis—most often syphilis of which its victims are ignorant; and, as soon as a suitable treatment is entered upon, it is cured with the greatest rapidity. Rest, elevation of the limb, destruction of the tubercles by nitrate of silver, an occlusive bandage with pitch plaster or emplastrum de Vigo, the iodide of potassium in very large doses, mercurial frictions, if necessary; these are the means to employ, and they will give us unhoped-for results. We must be careful not to confound these cases with the cases of malignant syphilis which are so common in alcoholics, in those of a lymphatic temperament, and in persons debilitated by fatigue, privations, or excesses. These latter patients take mercury badly, and sometimes can hardly ever tolerate the iodide of potassium. They must first be given a course of hygienic measures, tonics, bitters, inhalations of oxygen, etc. . . . Besnier believes that the designation syphilis mutilans should be adopted to characterize the class of cases which we have been considering.

Treatment of Gonorrhœa.

Among the new methods for the treatment of gonorrhœa I may mention that proposed by M. Thiéry. He advises that we use as injection a parasitidal agent which acts without coagulating albumen. The following is the formula which he gives: Oil of sweet almonds, 100 grammes; powdered iodoform, 10 grammes. The injection is done in the usual manner, but is to be retained in the urethra about twenty minutes (see the *Progrès Médical*, March, 1887).

Dr. Etienne proposes to prevent the development of a gonorrhœa by putting a pledget of cotton steeped in a 1-50 solution of nitrate of silver within the prepuce, so that it covers the surface of the glans and the urethral orifice. The application, if rapidly made, produces no discoloration, and gives but little pain. A four per cent. solution of boracic acid may then be used to wash the parts with.

The Vesico-Vaginal Incision for Cystalgia.

On February 16, 1887, M. Le Dentu communicated to the Société de Chirurgie of Paris, the results he had obtained in two cases of vesico-vaginal incision. The first patient had metritis and cystitis; her pain was so intense, and so rebellious to treatment that an operation was had recourse to. The pains persisted for several days, then disappeared; six months later the fistula was successfully closed. The second patient was a tuberculous woman suffering from metritis and cystitis. The results obtained remained doubtful for a month after the operation; then amelioration began. Le Dentu did not close the fistula for fear of causing a recrudescence of the thoracic trouble. We need not, therefore, hesitate to have recourse to the vesico-vaginal incision in obstinate cases of cystalgia in women. L. BROcq.

UNUSUAL DISTRIBUTION OF HERPES ZOSTER.

To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES:

DEAR DOCTOR—At the last meeting of the New York Dermatological Society an informal discussion took place on the subject of zoster. One of the gentlemen had seen a case of brachial zoster, the day before the meeting, in which the lesions extended to the finger tips. Several other members present had seen cases in which the lesions extended upon the hand and fingers, but it was the general opinion that these cases are not at all common. In the July number of the JOURNAL Dr. Robinson reports two cases, one of which is beautifully illustrated in the colored plate. The day after I received this number of the JOURNAL Dr. Holt kindly referred to me a boy who had a zoster with almost precisely the same distribution of vesicles. In this case, however, the patches began at about the third dorsal vertebra, extended over the back and shoulder, thence down the anterior surface of the arm to the finger tips. A solitary patch of vesicles existed upon the anterior aspect of the thorax just at the margin of the axilla.

A few scattered lesions were also found upon the extensor surface of the arm.

Upon the hands the lesion existed principally upon the palms, a fact which I wish to emphasize, since, in the meeting referred to, the freedom of

the palms in these cases was commented upon. A freedom I believe to be due in a great measure to the thickness of the epidermis in this situation.

At the first visit there were vesicles upon the tips of the middle and ring finger and erythematous patches occupied the centre of the palm, the ball of the thumb, the inner margin of the palm and the roots of the middle and fourth fingers. Two days later deep-seated vesicles had appeared in all these situations. A number of vesicles also existed between the fingers and small clusters occupied the dorsal surface of the middle and fourth fingers near the roots of the nails. Pains had existed in the arm and shoulder for two days before the eruption appeared.

The treatment consisted in first carefully applying a wet roller bandage to the arm and shoulder and keeping it moist with a weak solution of carbolic acid. Under this wet dressing the vesicles shriveled up without rupturing, and the cure was completed with a simple dusting powder.

Yours very truly,

CHARLES W. ALLEN.

Items.

BURNS AND SELTZER.—Dr. Dubois has recommended (*Archives Mensuelles* No. 8, *Brussels*) irrigation of the part burned with the contents of a siphon of seltzer water. He attributes the analgesic action of this remedy to the combined action of cold and the carbonic acid.

SUCH IS FAME.—We quote the following from *The American Practitioner and News*, but to do no injustice we should add that it might have been quoted from any one of a dozen of our valued exchanges:

“**ARSENICAL ERUPTIONS.**—Dr. P. A. Moroon (*La France Médicale*) has observed the following variety of cutaneous eruptions from the use of arsenic: Erythema, papules, urticaria, vesicles, pustules, ulceration, skin bronzing. In each case the discontinuance of the drug caused the disappearance of the rash.—*London Medical Press*.”

To get killed in war and have your name spelled wrong in the papers is bad enough, but to continue in the flesh and see yourself called *Moroon* by your contemporaries and friends all over the country, and your views attributed to some mythical Frenchman or Briton, is worse than death upon the field of battle. The scissors are surely mightier than the sword when they inflict such wounds.

TRAINING SCHOOL FOR MALE NURSES.—To enquiries which have recently been made, both through the daily papers and the medical press, as to the existence of a training school for male nurses, the answer has been given, that none such existed.

We are pleased to note that such a school has been established at the Charity Hospital, under the direction of the Commissioners of Public Charities and Corrections. Dr. James F. Ferguson is chairman of the board of managers.

This hospital has long had an excellent training school for females, and

as the Venereal and Dermatological Service is probably the most important one in the country, it will be of interest to our readers to know that men will be carefully trained, along with other things, to nurse this class of cases.

TITLES OF THE PAPERS to be read in the Section of Dermatology and Syphilography of the Ninth International Medical Congress:

1. Lupus Lymphaticus, with drawings. By Mr. Jonathan Hutchinson (London).
2. Das Seborrhoische Ekzem. By Dr. P. G. Unna (Hamburg).
3. Hydroa, and its Relations to Pemphigus, Herpes, Dermatitis Herpetiformis (Dühring). Impetigo Herpetiformis (Hebra), Herpes Gestationis. By Dr. T. Colcott Fox (London).
As an introduction to a general discussion of the subject.
4. Treatment of Syphilis by Injections of Insoluble Mercuric Salts. By Dr. H. Watraszewski (Warsaw).
5. La Lepre Observée à Constantinople. By Dr. Zambaco (Constantinople).
6. L'Elephantiasis des Arabes Chez les Enfants. By Dr. Moncorvo (Rio de Janeiro).
7. A New Method of Treating Disease of the Skin Locally. By D. H. Valentine Knaggs (London).
8. Einige Trophoneurotische Gefässaffectionen. By Prof. E. Schwimmer (Buda Pest).
9. Electrolysis in Dermatology. By Dr. I. N. Bloom (Louisville).
10. On the Occurrence of Ulcers Resulting from Spontaneous Gangrene of the Skin during the Later Stages of Syphilis, and their Relation to Syphilis. By Dr. Hermann G. Klotz (New York).
11. Double Comedo. An Anatomico-Pathological Study. By Dr. A. H. Ohmann-Dumesnil (St. Louis).
12. Erythematous Lupus of the Hands. By Dr. A. H. Ohmann-Dumesnil.
13. A New Method of Treating Favus and Herpes Tonsurans of the Scalp. By Dr. H. J. Reynolds (Chicago).
14. Area Celsi. By Dr. A. Ravogli (Cincinnati).
15. Lupus Erythematosus. By Dr. A. Ravogli.
16. A Contribution to the Knowledge of Impetigo Herpetiformis (Hebra). By Dr. Josef Zeisler (Chicago).
17. Rectal Alimentation in Diseases of the Skin. By Dr. J. V. Shoemaker (Philadelphia).
18. Vaccination During the Incubation Period of Variola. By Dr. William Welch (Philadelphia).
19. Studies in Hirsuties. By Dr. G. H. Rohé (Baltimore).
20. A Unique Case of Spreading Melanosis, with Exhibition of Subject. By A. R. Robinson.
21. The Pathology and Treatment of Alopecia Areata. By A. R. Robinson
As Introduction to a General Discussion of the Subject.
22. Sur le Mycosis Fongofide d'Alibert. Nouvelle Communication Clinique avec Recherche de Microorganismes. By Prof. Tommaso de Amicis (Naples).

The titles of the papers expected from Professors Hebra, Kaposi, Neumann, Fournier, Leloir and others have not yet been received.

A. R. ROBINSON, *Chairman of Section.*



Dr. Wyder's Case of Elephantoma

JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

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VOL. V.

SEPTEMBER, 1887.

No. 9.

Original Communications.

NOTE RELATIVE TO A CASE OF XANTHOMA MULTIPLEX.

BY

JAMES NEVINS HYDE, M.D.,

Professor of Skin and Venereal Diseases, Rush Medical College, Chicago.

A. E., twenty years of age, of Jewish nationality, unmarried, presented himself for examination April 27, 1887. He weighed one hundred and twenty-five pounds, and, beyond his cutaneous ailment, gave no history of ill health, save a slight bronchial irritation which had been annoying him for a few weeks. His father and mother were living, both in the fiftieth year of life. Two other children beside the patient were living and in good health; four had died in infancy, of which number one was killed by accident.

The mother, examined by me, was found to have a varicose ulcer on the left leg. She had also a split-pea-sized nodule of xanthoma near the inner canthus of each eye. No history of xanthoma in other relatives was obtained.

The patient stated that he had never suffered from hepatic disease nor from any form of icterus. His present disorder began ten years ago, in his tenth year, by the appearance of pin-head-sized, yellowish points over the extremities and near the inner canthi of the eyes, where larger lesions of similar character are now visible. He could not say whether the eyes or extrem-

ities were first affected. The growth of these lesions up to date has been slow and by both multiplication and coalescence of split-pea-sized nodules of yellowish tint.

On the right upper lid, near the inner canthus, is a split-pea-sized xanthomatous nodule.

On the left upper lid, and in a similar situation, is a xanthomatous nodule as large as half a split pea.

In the centre of the left upper lid is a distinct circular, large pin-head-sized xanthomatous point.

The palpebral lesions are, therefore, symmetrical in distribution. They are not represented in the accompanying illustration because the patient objected to photography of his face.

The only other lesions existing upon the skin are represented in the lithograph taken from a carefully executed photograph, and occur upon the extensor faces of the third metacarpophalangeal articulations of each hand, over the dorsum of the fourth metacarpophalangeal articulation of the left hand, and over the elbows and knees. The size and shade of the plaques of xanthoma tuberosum existing in these localities are well suggested in the portrait. The symmetrical disposition of these plaques is not perfect: that, for example, on the left hand being somewhat larger than that on the right, and there is not exact correspondence between the two sides as shown in the other plaques upon the extremities, but the symmetry is sufficiently marked to be strongly suggestive and interesting.

All the plaques shown are sharply defined, distinctly roundish, oval or reniform in outline, irregularly mammillated on the surface, saffron-yellow in hue, save upon the hands, and evidently composed of pea-sized nodules of xanthomatous tissue well projected from the surface. The excess of the peripheral growth above that recognized in other parts of each plaque suggested in places a clearing centre, but no such complete involution had anywhere occurred.

The peculiar rose-reddish color of the tubercles upon the hands as distinguished from the saffron-like hue of the other lesions is characteristic of the disease. It is clearly indicated, though, in consequence of the paucity of stones employed, poorly represented in the manual lesions figured in one of Tilbury Fox's plates of xanthoma.

It is interesting to note that the sites of the tubercles portrayed in Fox's case were the dorsal surfaces of the metacarpophalangeal articulations, the largest capping the third joint.

The plane lesions and linear or ribbon-like xanthomatous infiltrations of the palms exhibited in Fox's plate, were not seen in the case here described.

Cases of multiple extensive, and even generalized xanthoma, usually of the tuberoso type, with localization of lesions upon the extensor faces of the extremities, though rare, are recorded in sufficient number to establish a full clinical portrait of the shades of the disease. Schwimmer, Hutchinson, and others have reported such cases abroad. Eichhoff¹ has recently described a case of multiple lesions in a child only one and one-half years of age with plaques on the limbs. Hardaway's interesting case with the lesions upon the trunk arranged as in zona was reported to the American Dermatological Association in 1884; and in the following year Robinson² exhibited a woman, aged forty, to the N. Y. Dermatological Association, with lesions existing solely upon the elbows.

Hutchinson has cited several cases where, as in the present instance, more than one member of a single family was affected with the disease; but neither these facts nor that cited below seem sufficient to justify positive conclusion as to the origin of the malady.

I deem it of sufficient importance in connection with the etiological phase of this subject to add here a fact which came under my observation in the past twelvemonth, bearing on the possibility of origin in some cases of xanthoma. A middle-aged woman of wealth and social position was brought to me by her physician and found to exhibit multiple, typical, plane lesions of xanthoma, plentifully sprinkled over the upper and lower lids of each eye, the greater number of which were grouped near the inner canthi. She had learned from a servant that the *cimex lectularius* had been discovered in some bed-clothing, and had gone to a closet where, upon a high shelf over head, stood a large-sized vial of a strong solution of corrosive sublimate intended for use as a parasiticide. In attempting to reach this vial, she spilled its contents over her eyes which were fortunately protected at the moment by an instinctive closure of the lids. A quantity of the solution was swallowed; but the skillful administration of antidotes by her physician was successful in saving her life. Soon after the relief of the dermatitis produced by the application of the corrosive fluid to the eyelids, the xanthomatous lesions appeared.

¹ *Deutsch. Med. Wochenschrift*. No. 4, 1884.

² *Jour. of Cut. and Ven. Dis.*, 1885, p. 345.

ON THE CHOICE OF OPERATION FOR VESICAL CALCULUS IN CASES COMPLICATED BY PROSTATIC ENLARGEMENT.

BY

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REGARDED critically, it is somewhat astonishing how little influence prostatic enlargement has upon the choice of operation as between cutting and crushing for vesical calculus. And this smallness of influence surely does not appear at first glance. Subtracting the diseased states of the bladder, urethra and kidneys, which are frequently caused by prostatic enlargement, and which might equally be caused by other diseases, or by the residence of a stone in the bladder, without prostatic disease—we come to the only essential influence that prostatic enlargement may have, viz.: mechanical interference with the crushing and evacuating apparatus. With the crushing instruments, prostatic enlargement mainly interferes by contracting the vesical outlet to such an extent as either to render their use mechanically impossible, or to necessitate more bruising there than the surgeon deems advisable. This condition is very rarely found, and since the skill of the operator comes into play here, no rule can be laid down for guidance. This, however, applies only to the crushing procedure. When we come to consider the matter of the evacuation of fragments, and especially of the total and complete evacuation of fragments, we find that prostatic obstructive disease plays a far more conspicuous part. It may so narrow the vesical neck as to necessitate the use of too great force in the introduction of the tubes; it may render the size of the tube too small for effective work; by lifting up a bar it may prevent the getting of the point where it is requisite to have it, and it may have caused the development of such a deep bas-fond, or other vesical irregularity, as to completely prevent the evacuation of the last fragments. And in the evacuation of the last fragments, the rather free movement of the tube is necessary when there is a marked bas-fond or even moderate sacculation. The indispensable condition—the condition that renders litholapaxy the operation of choice—is the total crushing and complete evacuation of the stone.

When some cutting operation is chosen for the removal of stone in prostatics, that choice is usually made for vesical reasons, or for some consideration connected with the volume or

hardness of the stone itself. The bladder is inflamed or excessively irritable, contracted or sacculated; or the stone is too large to be seized by the lithotrite, or too hard to be crushed, and so the surgeon makes pre-rectal or hypogastric section. I may be mistaken as to the general practice on this point, but I believe that section is very rarely made for purely prostatic reasons. That is to say, with the intention not only of removing the stone, but of reducing the size of the prostate also, and thus of reducing, in intensity, at least, the causes that were most potent in the production of the stone as well as lessening the sufferings of the patient in after years.

Within the last few years, some clinical experience of mine has led me to the belief that this consideration should have more weight than is usually accorded to it; and this opinion has continued to gain ground with me in face of the well-known dangers that surround cutting operations in persons old enough to have hypertrophic obstructive disease.

Not to weary with detailed recital of cases, let me say that I have, since 1884, operated for stone—by pre-rectal section—upon four cases, all of which were complicated by marked enlargement (hypertrophic) of the prostate, and have had opportunity of carefully observing one similar case in the practice of a distinguished friend.¹ All the cases were successful and all are now living, save one who died ten months after operation of apoplexy. In three of these cases—in two of my own—I had the somewhat exceptional opportunity of passing the finger a second time into the prostatic sinus and vesical neck, and hence had good opportunity of making observation of the changes in the prostate wrought by the first operation. In one I had failed to evacuate the fragments entirely—for the stone had to be crushed—and I saw him again four months later, made a second incision into the membranous urethra where they lay, having come down from the bladder, and was enabled to pass the finger

¹In all these cases the operative procedure was the same: Median perineal urethrotomy with dilatation by the finger, this affording, as I believe, the shortest and safest perineal route to the vesical cavity. The knife was passed into the median line so as to strike the groove in the staff at the apex of the prostate; the membranous urethra button-holed and dilatation gradually accomplished with the finger. In no case was the prostatic lobe divided. I believe this greatly increases the danger in these cases. In two instances a bar at the vesical outlet was divided with the straight, blunt-pointed bistouri. The floor of the prostate was lowered and straightened, and a large soft catheter was tied in and the bladder drained for six to fourteen days, or as long as the patient would bear it.

In all the cases section was rendered necessary by the state of the parts; in none was it the operation of choice, my preference being, in common with the majority of other surgeons, for litholapaxy, when that more benign operation can be done and will accomplish the purpose.

up and measure the size of the prostate a second time very accurately by bimanual manipulation. In two others there was recurrence of stone (in both cases after the lapse of fourteen months) and a repetition of the same operation permitted not only rectal but vesico-prostatic measurement (digital). In all three cases, at the first operation, it was not possible to reach the vesical cavity with the finger-tip, the finger being passed through the median perineal incision into the membranous urethra. In two of these cases the forceps had to be relied upon entirely for extraction (multiple calculi and small), and in one, crushing was done through the perineal wound with the large lithotrite of Bigelow. At the second operation, in each case, it was not only possible to reach the vesical cavity with the finger, but to explore the condition of the vesical walls by making deep pressure upon the hypogastrium. In one of the cases I estimated the reduction in the size (length) of the prostate at about one-third, and in the other two at fully one-fourth. As a still more satisfactory evidence of improvement, it may be said that at this time there is no residual urine of any account in either case, and only one of them rises at night to pass water—this one only once. The fact is not to be lost sight of here that in all three cases the bladder was drained twice, and for considerable intervals, by the tube introduced through the perineal wound.

Of the two other cases (operated upon but once) I can say but little that is so conclusive as to the reduction in the size of the prostate. Every one is aware of the difficulty of making accurate measurement of the prostatic sinus or the condition of the vesical neck when the finger in the rectum is the only reliance; or of estimating the size and shape of the deeper prostatic parts with the catheter or sound. Even with a catheter in the bladder and a finger in the rectum, a variety of conditions may escape notice, which conditions are at once detected by the finger in the bladder-neck. Of one of these cases, however, I can say that rectal palpation shows distinct decrease in length, thickness and hardness of the prostate. This patient (æt. 65) is gouty, and very slight freedom in eating or drinking causes vesical irritation which quickly subsides after a mercurial purge and restricted diet. Tested several times, I find a record of $2\frac{1}{2}$ drams residual urine. He does not use a catheter at all, and does not rise at night to pass water. Of the other (æt. 77), very feeble at time of operation, and evidencing arterial degeneration, I can say nothing,

having had only one opportunity of examining, *per rectum*, since, and that at an interval too short to afford full opportunity for much prostatic change. The gland seemed to be diminished somewhat in size and softer.

There is one other consideration that should have weight here, and that is the fact, patent enough in some cases, that the prostatic hypertrophy is the cause of the stone. It is, in many cases, the cystitis consequent upon prostatic enlargement that furnishes the colloid which influences, first, crystallization, and second, the cementing of the salts together into a calculus. One of my patients well illustrated this point. For many years he had, to my knowledge, passed large quantities of uric acid sand, especially after any freedom at table, but never had calculus in his bladder (though all the other conditions were favorable) until he passed over the frontier and got prostatic hypertrophy and cystitis. Then a vicious circle was set up. The obstructive prostatic disease caused cystitis, the cystitis, stone; the stone increased the cystitis, and, reacting upon the prostate, caused greater enlargement by adding to the hypertrophy another element—inflammation of the chronic sort. I doubt if this vicious circle would have been broken as effectively by any other operative procedure as it was by section and drainage.

And this brings us fairly to the question: Was it the hypertrophic, or the added inflammatory, changes that were reduced by the section and drainage? There is but little in my experience or observation that would enable me to decide; but the question is one worth our while to determine. That inflammatory action may have much to do with causing a part at least of the prostatic enlargement in these cases, the following clinical observation led me to believe:

Last fall I was called to see a case in the practice of another surgeon, who had tapped, through the rectum, the bladder of a man aged sixty-two, long a sufferer from chronic cystitis, the result of hypertrophic obstructive disease of the prostate. The patient was dying when I saw him, and an autopsy revealed a bladder that was atonic from chronic inflammation, soft and friable. The prostate was greatly enlarged, mainly in its longitudinal diameter. There was no stone and no ulceration of the viscus. Microscopic sections of this prostate showed hypertrophic changes not only, but marked inflammatory infiltration also. Looking at these sections, it appeared quite possible that absorption of these inflammatory products alone would bring about a

reduction by at least one-third in the size of the gland. In no way might this be so promptly and thoroughly done as by section and drainage. It would be of practical importance to know also if any reduction in the hypertrophic tissue came about after such an operation. In all the cases I have had opportunity of observing, the reduction in size came about in so short a time as to justify the belief that it, and the consequent benefit accruing to the bladder, was due to absorption of inflammatory exudation, rather than reduction of hypertrophic tissue.

But would not the prostatic enlargement be equally reduced by any other operation which would radically deal with the stone? *Ex. gr.* litholapaxy. I believe not, or, at any rate, not to the same extent. In simple inflammatory enlargements and in cases where the cystitis is due to, or is maintained by, the calculus, the more benign operation of litholapaxy is clearly indicated. But it will be different when the prostatic hypertrophy has been the beginning of that vicious circle above alluded to. In that case the removal of the stone is but a part of the aid our art offers to these patients. Vesical drainage and vesical rest are not secured by simply removing the calculus. One of the cases forming the basis of this paper—the one in the practice of my friend—has a distinct bearing upon the point at issue. One year before the first perineal section a stone was crushed and pumped out of his bladder after the method of Bigelow. Recurrence coming about, three small calculi were removed by medium perineal section. I could not make out, by careful examination, that the size of the prostate had been lessened by the litholapaxy; and the quantity of residual urine had not been reduced nor the vesical distress relieved. After the first section, however, there was a distinct amendment in both instances. Nevertheless, recurrence again came about, and a soft, phosphatic mass accumulated, and a second perineal section—this time with drainage—was made, with the result of curing the patient. Now, there is no residual urine; the patient voids the urine six to eight times in the twenty-four hours, and the prostate is markedly reduced in size. It is true that recurrence of stone came after litholapaxy, and the presence of the calculi obscured the result as far as the effect upon the size of the prostate is concerned; but the same condition existed after the first cutting operation, and yet, under more favorable opportunity for measurement, the prostatic enlargement was markedly reduced, and the symptoms dependent thereon abated.

In dealing with these questions, mere statistics do not avail us. These tables deal, as they should, with the immediate results of the various operations for stone as they relate to the items of mortality and recurrence. The ultimate results upon the size and condition of the prostate, the bladder and the quantity of residual urine, important as they are to this class of patients, are not touched at all—cannot be. Individual experience, therefore, must have an important influence upon the operator's mind, and it is with the hope of adding the experience and observation of others to my own that this paper has been written. For the ideas here suggested have been raised in the operating-room and at the bedside rather than in the library, just as the writer has had more time for work than for a study of the literature of the subject.

S. E. COR. 26TH AND OLIVE STREETS.

AN UNUSUAL CASE OF DERMATITIS MEDICAMENTOSA, DUE
TO CUBEBS AND COPAIBA.¹

BY

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UP to quite a comparatively recent date, the literature of dermatitis medicamentosa was very unsatisfactory. After some time, the reports of cases began to increase in number, and some system was evolved out of this material. In spite of this, however, the literature of this subject is even to-day rather meagre, and cases are frequently reported whose parallels have not before been observed and recorded. This is in part due to the fact that these eruptions are rather the exception than the rule, and also because they are not always recognized, and are thus completely lost, as far as any records are concerned. Sometimes the eruption disappears before the attending physician has an opportunity of availing himself of the aid which may be required in such cases.

It is for these reasons that I take the present opportunity of reporting a case which is not devoid of interest, and may be of some value to those engaged in the general practice of medicine.

Dr. A. F. Bock, of this city, called me in consultation, December 29, 1886, to see a young man who had an eruption which resembled smallpox in a great degree. Dr. Bock has

¹ Read before the Missouri State Medical Association, May 11, 1887.

treated a large number of cases of variola, and is thoroughly familiar with the dermatic complications of the disease. Upon examining the patient, a young man about 27 years of age, it was found that he had a number of dark red papules, of the size of a small split pea, distributed on the wrists and face. They were rather discrete, and, besides the localities mentioned, a few were scattered over the body. There existed also the indication that others would soon make their appearance. There was no itching or any other subjective symptom that was noticed by the patient.

Upon closely interrogating the young man, it was found that he had no headache, no pain in the back, and no fever that amounted to anything. It was also learned that this young man had gonorrhœa, and was taking a mixture kindly prescribed by an obliging friend. Instead of taking the amount ordered, he doubled the dose in quantity and increased its frequency considerably. Upon examining the mixture it was found to consist mainly of cubebs and balsam copaiba.

With this history, I concluded—as Dr. Bock had suggested—that the eruption was due to the ingestion of the medicine and its further use was ordered discontinued. Wishing to watch the progress of the case, I called twenty-four hours later and found that there was considerable tumefaction of the hands and face. The eruption had disappeared from the face, but had extended to the whole body and assumed a new appearance. The papules, that existed the day before, had flattened, a large number of millet-seed-sized ones had appeared and now the distribution was in the form of blotches somewhat crescentic in shape. In fact, the eruption now simulated measles. In no other detail, however, did it resemble that exanthem. There was no fever, no suffusion of the eyes, no catarrh. There were no subjective symptoms connected with the outbreak.

Twenty-four hours after this, on December 31st, the eruption had assumed still another form. The small papules had flattened and certain numbers of the blotches had coalesced, giving rise to large macules of a dark reddish color. The color, however, was sufficiently bright to simulate to a certain degree the rash of scarlatina. After this, a slight furfuraceous desquamation took place and the skin of the patient was once more normal, the process occupying but a few days. He did not renew the medicine which had caused this eruption, but was treated by other means by his physician.

In making an analysis of this case, it is unnecessary to make

a complete review of dermatological literature. The majority of authors, when describing the eruption caused by copaiba, speak of the urticaria-like form as the most common—which it is. Itching is one of the prominent symptoms here. In Bumstead and Taylor, the statement is made that it “itches sometimes,” whilst Hyde says that the eruption due to cubebs and copaiba always itches. Tilbury Fox says that the itching is intense in the eruption from copaiba; and Berenguier states that there is no pruritus accompanying the rash due to the ingestion of cubebs. In the case detailed above no pruritus existed.

As to the forms of this eruption, we find that they are various. Copaiba will produce urticaria, erythemata, a cherry-red maculo-papular, or papular form, a miliary form, hyperæmia, urticaria without wheals (T. Fox), erythema papulatum, large flat papules, bullæ developing out of erythematous redness (Hardy), red papules, and an eruption, one part like measles and another like scarlatina (T. Fox). Cubebs will give rise to a papular roseola, followed by furfuraceous desquamation in a few days; a red discoloration and millet-seed-sized papules, and it is generally regarded as rarely producing an eruption. Copaiba and cubebs in combination produce discrete macules, maculo-papules, and dark mulberry-red patches.

Such is a brief *résumé* of the character of the various forms of eruptions, following the ingestion of cubebs and copaiba, singly and in combination.

In the case which I have reported, there existed a condition which is not often observed in these cases, viz.: the different changes that occurred, and the many different forms assumed. As a rule, medicinal eruptions do not undergo many phases in their evolution, and in the case of the eruption due to copaiba and cubebs, two forms are generally the greatest number assumed. In this case there were three distinct forms, with as many intermediary or transitional stages, not taking into account the final act of desquamation. An interesting point in connection with this case is the fact that the eruption should have simulated the three principal exanthemata in succession.

Although it may be said that, when viewed critically, the resemblance was not perfect, yet it was sufficiently great to have deceived any one not quite careful in making an examination. In fact, this resemblance existed to such a degree as to

be quite striking, and the greatest point of difference probably lay in the color. It is well known, though, that the power of delicate discrimination between shades of the same color, and especially of red, is wanting in the majority of persons.

One question which naturally suggests itself is, was not this multiform feature of the eruption due to the combined action of the two drugs? It is very probable, although the same reason will not explain the absence of pruritus.

Another interesting feature of the case is the manner in which the skin was involved and the amount of surface which became the seat of the eruption. The whole body was attacked, the starting points being the wrists and face. Despite the fact that so much surface was involved, it produced no general disturbance, and the patient only complained of the confinement to which he had been subjected for about a day, when the family had been informed that his trouble might prove to be small-pox.

Why the slight tumefaction of the hands and face should have taken place, after the disappearance of the papules and their flattening, I cannot explain. Were it not for the absence of pruritus, we might account for it by regarding it, as Tilbury Fox did in some cases, as a hyperæmia like urticaria without wheals, or, rather, with undeveloped wheals, which had coalesced.

Prof. E. Schwimmer regards these eruptions, due to the internal administration of drugs, as "a physiological effect, the vaso-motor nerve-centres suffering a change as in the acute exanthemata"—a reason which might to a certain degree account for the various forms observed in the case related. For it might be contended that a certain unabsorbed portion of the drugs, becoming absorbed, acted *de novo* and gave rise to a new eruption which, combined with the remains of the one just disappearing, gave rise to the peculiar forms observed. But it is the very fact that only certain portions of the body are affected by whole series of drugs that has given rise to the vaso-motor theory and consequently, somewhat vitiates the argument in the present instance. Still, Morrow, in his late work on "Drug Eruptions," advocated the view that they are due to some action upon the vaso-motor system of nerves and states, in regard to these eruptions, that "their very caprices and contradictions constitute a strong proof of their neurotic origin, suggesting a modification of the controlling, regulating influence exercised by the nerves upon circulation and nutrition."

CRITICAL STUDY OF A CLINICAL STUDY OF ICHTHYOL AND RESORCIN.

BY

W. H. DUNLAP, M.D.

IN a recent number (June, 1887) of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES is an article from the pen of Dr. Jackson, entitled "Ichthyol and Resorcin: A Clinical Study of Their Effects." The judgment arrived at by the author, as a result of his "clinical study," is certainly not very favorable to the two remedies as therapeutic agents, ichthyol falling wholly under the ban and resorcin escaping a like fate by only a hair's breadth. This interesting contribution can be looked at in two ways, viz.: as intended to overthrow the conclusions reached by Dr. Unna, and contained in his monograph, "Ichthyol and Resorcin als Repräsentanten der Gruppe reduzierender Heilmittel," or as an independent series of observations instituted for the purpose of showing the therapeutic value of these drugs in diseases of the skin other than those mentioned by the Hamburg dermatologist. It cannot be said to have fulfilled either of these ends, and it will be seen that, though seemingly overthrowing Unna's position, it really confirms anew the facts advanced by him, and that, as a "study," it is valueless, since it gives us no new data in regard to the physiological action, or therapeutic worth, of the drugs under consideration—nothing, in short, not fully described before. Let us now very briefly, bearing the above in mind, examine this "clinical study" and see what authority the writer has for the statement that "ichthyol is an *unreliable* preparation when used alone; in some cases it is of *apparent* benefit when exhibited as an adjuvant; but it is not as good as many other old and well-approved remedies." One case, quoted in full from the rosacea list, will suffice as a typical example of the methods of observation, treatment and description of all.

"CASE 1.—M. S——, M., æt. 39. Rosacea of one and one-half years' standing. June 17, 1886, ordered a ten per cent. solution of ichthyol (pure) in water. July 15th, face somewhat paler, continue treatment. July 31st, face much redder and skin inflamed; stops ichthyol." In the remaining cases the effect was no better. Certainly these results do not appear to sustain the proposition that "ichthyol has its widest application to all forms

of rosacea," and Unna must be an enthusiast. But let us not hasten to condemn—other factors are to be taken into consideration, e. g., there are rosacea and rosacea; the strength of the preparations used—for what will benefit one case will surely act injuriously in another—and the susceptibility of the skin itself; all of which, for success, must be borne in mind, and all of which are especially emphasized by Unna as follows (page 30): "The strength of the ichthyol preparation for external use must be determined from the condition of the epidermis and the more or less irritable or indolent state of the vessels." Then too, the form of the rosacea in which the drug is valuable is very clearly defined, and it is distinctly stated that in the milder forms—those inclining to eczema and erythema—only very weak ointments, pastes, or varnishes are to be applied, and in many instances the *external* use of ichthyol must be *entirely* omitted (page 32). Finally, he remarks, there is but *one* form of rosacea in which ichthyol can be used with a free hand, and this, to quote, "shows us, typically stamped the picture of a hard, knotty acne on a dusky, bluish red and swollen base—the epidermis is thick and raised into irregular protuberances. The tubercles and pustules, with which the surface—under these circumstances—is covered, are distinguished from those of acne through their greater hardness and persistence; the small quantity of pus contained in them, which does not—as in acne vulgaris—constantly hold comedos. The hyperæmia is venous and does not yield as readily to external irritations. The skin is as little inclined to eczema as that of acne (page 31). Just what form of ichthyol treatment would have been suited to the case quoted, it is of course impossible to say. We have no description to guide us. The disease may have been spread over the whole face, or may have been restricted to nose and cheeks or chin. The state of the skin is not noted. Is there acne complicating this case? Is there thickening of the epidermis, or merely a dilatation of the vessels? We are not informed, and must be content with the simple statement "rosacea." But if Case 1 were simply rosacea, uncomplicated by acne nodes, hypertrophy, etc., why, in direct opposition to the precise rules quoted above, prescribe a 10 per cent. solution? From the meagre data given, this case would probably fall into the class of rosacea, with tendency to eczema and erythema, in which only the mildest external ichthyol preparations are to be employed, or, better still, omitted altogether, and the treatment confined to the *local* use of hot

water, and the *internal* administration of ichthyol. It is not surprising that, after nearly six weeks' steady use of this solution, the "face was redder and the skin inflamed." These, as Unna has pointed out in the early pages of his work, are the physiological effects produced by these "reducing agencies," when continuously applied, in strong, or even moderately weak, doses. The only wonder is that they did not sooner manifest themselves. Certainly Jackson failed with ichthyol in rosacea, but is he justified in condemning the drug, and deciding that Unna's results are the outcome of enthusiasm? Has he not rather failed to come to the same conclusions, because, first, he did not know the natural physiological actions of the remedy with which he was experimenting, and second, because lacking this knowledge, he did not understand how to use it? The consideration of the second class of diseases treated by Jackson, viz.: eczemas, presents some difficulties. It is true his success was no better than with rosacea—four cases being aggravated and two treated with no effect. The difficulty is this: Unna has specified certain forms of eczema, in which *only* he claims that ichthyol can be used with decided benefit, viz.: nervous eczemas, and of the parasitic eczemas, the tuberculous and intertrigenous, while Jackson records cases of eczema papulosum, vesiculosum, madidans, etc., which, being only names applied to different stages of the eczematous process, throw no light upon their different causes, and it is, therefore, absolutely impossible to tell whether any of his cases were suited for the ichthyol treatment. Any light which might have been obtained on this point, had the lesions been at all—not to say carefully—described, is also wanting, and we must, therefore, confine ourselves to an examination of the treatment. This is most clearly stated by Unna on page 40, where he says that the applications are to be, "in the beginning, on the groups of vesicles which, *as yet*, are *unscratched*, in order to cause a rapid drying up of these vesicular groups; but if, with the idea of preventing a return of the vesicles, one continues the use of the ichthyol, in the same strength, on the already dried places, almost certainly, after a time, will a new eruption appear. It is, therefore, a practical point to use ichthyol externally, only periodically, restricting its application to newly-appearing groups of vesicles, and to substitute, for the external use, a steady internal administration." Without quoting further from Unna's plan of treatment—which is more or less modified by the peculiar forms of eczema with which he has to deal, by the parts affected, and by

the condition of the skin—let us look at Jackson's cases. Granting that his diagnosis was correct, and the cases proper ones for ichthyol, it is plain that, in carrying out the treatment, the directions mentioned above, such as reducing the strength of the external applications, or omitting them altogether, have not been observed; and it is not strange that, after a twenty days' use of a 10 per cent. ichthyol ointment (Case 4) the patient is worse, or that, in (Case 5) an infant of seven months, after sixteen days' use of a 5 per cent. ointment, it was necessary to "stop" the ichthyol. These results are precisely those mentioned by Dr. Unna, as certain to occur, and are the natural inflammatory effects, produced by these reducing agencies, when too long continued or exhibited in doses too concentrated. Before leaving this portion of the subject, one or two other noticeable points must be briefly mentioned. In Case 5—eczema vesiculosum, in an infant of seven months—a 5 per cent. ointment is given; while in Case 6—eczema papulosum, in a child of two years—only a 3 per cent. preparation was used. Is not this reversing the usual rule for prescribing, to *decrease* the strength of the medicament, as the patient's age *increases*; and should we not expect that an eczema papulosum would demand stronger medication than an eczema vesiculosum? In Case 8 we are confronted with a diagnostic puzzle, viz.: an "eczema vesiculosum upon a syphilitic base." Has the patient syphilis and eczema, or has he a syphilitic eruption like an eczema, or an eczema which simulates a syphilis? If the disease was syphilis, why use ichthyol at all; if not, why diagnose eczema on a syphilitic base? Case 10 is especially valuable, as showing how—unintentionally, it is true—the author confirms Unna's observations. This was a case of "eczema madidans scroti, partly healed by other remedies" which was treated with a 3 per cent. ichthyol ointment, and in three days (March 19th–22d) converted from a "dry eczema into a raw and very itchy one." Could anything else have been expected? Had not Unna—when speaking of the physiological actions of these remedies—called attention to the fact that "there are tender places on the epidermis (eyelids and penis) which on the application of even weak doses to the normal skin, respond with the phenomena of the strong effects, acute swelling and inflammation" (page 6). The results of ichthyol in acne are, indeed, disastrous, for we find none of the cases cured, two made worse, and only one improved. Without quoting any of these cases in detail, let us call attention to the fact that Jackson again fails to follow in

his treatment the directions suggested by Unna. For example, in an acne vulgaris of one year (Case 14), he prescribes a 10 per cent. ichthyol ointment and three drops of the drug internally, A. M. and P. M.; while in Case 15 an acne vulgaris of three years, he exhibits ichthyol soap and five drops of the drug internally, A. M. and P. M. Why does he not reverse the prescription as apparently he should do, for, naturally, the disease of longer duration would present the greater epidermic thickening and changes, and be more suitable for the stronger application. His method is directly opposed to Unna's teaching, who insists emphatically, in acne, as in rosacea, that the condition of the skin must determine the strength of the ichthyol application and that the same rules of treatment so minutely detailed for rosacea apply in acne. It is not wonderful, therefore—remembering the known physiological actions of these reducing remedies—to read that an acne vulgaris treated with a 10 per cent. ichthyol ointment was made worse, or that an acne indurata of one year, treated for seven days with a 30 per cent. ointment was converted into an artificial eczema. In regard to Unna's views of the ichthyol treatment of sycosis, it is sufficient to quote this statement (page 57): "In sycosis, ichthyol is of value only in the tested combination with tar and soft soap." It merely plays the rôle of an adjuvant in this disease. The unfortunate results of the ichthyol treatment of ulcers, given by Jackson, cannot be considered as injuring the drug in a therapeutic sense, for, while ichthyol influences the calibre of the blood vessels, and may have a good effect on varicose veins, by causing contraction when painted upon them, and thus, indirectly influence the ulcer, applied directly to the sore it would be certain, even in a 3 per cent. strength, to produce its strong reducing effect, viz., high degree of inflammation, œdema, and great pain. I have thus briefly tried to show that this article can in no sense be considered as disproving the observations of Unna on ichthyol. It has failed in two prime essentials at least. First, the cases are not in any way proved to be those in which Unna claims for ichthyol any value; and second, the methods of using the drug—strong applications where weak ones should have been prescribed, and *vice versa*; and continuing the use of the remedy when it *should* have been *omitted*—were such as to utterly invalidate the deductions had the cases been parallel ones to those cited by Unna. The observations of Dr. Jackson on resorcin can be dismissed with few words. They can be looked upon in no sense as either for

or against the conclusions advanced in Unna's article on this drug, since—save in two instances, eczema and psoriasis—the classes of disease in which Jackson made his experiments were not those in which Unna recommends the use of the drug, and the portion of his paper devoted to resorcin can have no other purpose than to embody his independent observations. It may be well to remark in this connection that since the appearance of Unna's original article, a greater experience with resorcin has fully confirmed him in his earlier estimate of its value, especially in the forms of eczematous disease, which he definitely describes and classifies, psoriasis, sycosis and epithelioma, besides extending its value as a therapeutic agent in other directions. At a later date it is possible, and certainly much to be desired, that the results of his experience will be embodied in a dermatological study, which will be not only interesting, but valuable, scientifically and practically, to the medical world. Having discussed this paper in the light of an argument against ichthyol and resorcin, let us now see whether the observations are worthy to be called a study in the true sense of the term. The patients chosen for the purpose were ambulant patients—not usually noted for exactness in following details of treatment—and all dermatologists are aware that the manner of making the application is a most important point in the successful *study* of a remedy. A very simple and harmless one, improperly applied, or too long continued, is capable of producing very injurious results. Then, too, ambulant patients are hard to control, and do not report for inspection frequently enough to enable one to study the effects of a remedy upon them. This certainly is true in the case under consideration, for, in Dr. Jackson's study, none of the patients are seen oftener than once a week, and, generally, once in two or three weeks. Meanwhile, what may not have occurred? Has the patient steadily used the remedy, just as it was ordered, and have no complications occurred to interfere with its actions? A scientific study of effects means a constant, daily watching and a careful noting, not only of the condition of the parts to be acted on by the remedy, *before* its applications, with any circumstances which may impede, or modify these effects, but also a careful description of the changes observed at the different examinations, together with the methods of exhibiting the drug in question. All these and many others, which it would take too much time to mention, go to make up a scientific study, and alone make it valuable, and all these are wanting in Dr.

Jackson's "clinical study." In conclusion I may say that a personal observation (extending over many weeks) of patients, in Unna's private hospital, who are visited twice daily, and of cases in his private practice (seen at least every second day) with whom ichthyol was in constant use, has convinced me, that we have in this drug, in certain clearly defined limits, a most valuable addition to dermatological remedies, and one which had Unna's enthusiasm in study and experiment been wanting, we should to-day be without.

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Correspondence.

PARIS LETTER FROM THE EDITOR.

The Special Hospitals of Paris—Vidal's Treatment of Lupus—Treatment of Syphilis by Hypodermic Injections—Extra-genital Chancres—Rarity of Chancroid—Treatment of Blenorrhagia—Genito-Urinary Surgery at the Necker Hospital.

THE readers of this JOURNAL are kept so well informed of everything relating to the progress of dermatology and syphilography in France through the quarterly letters of its accomplished correspondent, Dr. Brocq, that I find little of interest or practical value in these departments which has not already been communicated.

I have thought, however, that a few jottings of my personal observation of hospital work in this city during the past month may prove of interest to my readers.

Fifteen years ago I passed eight months in the Ecole de Médecine and hospitals of Paris, and returning after this long interval I find few changes in the character of the hospital work or even in the *personnel* of many of the hospital staffs. Many of the younger men who were then struggling into prominence have since achieved distinction and success, and now rank among the foremost in their respective specialties. Some of the older men have passed away or have become superannuated. Ricord still remains a prominent figure, his massive form unbowed by the weight of his eighty-seven years, his intellect undimmed and his interest in medical matters as active as ever. I saw him the other day at the Academy of Medicine—the centre of a circle comprising Fournier, Besnier, Vidal and others, whose reverence and regard for the great master were marked and evident.

Many physicians and surgeons are connected with the same hospital during their entire lifetime of active work and the hospital and the man thus become identified in reputation. Mauriac, for example, has been connected with the Hôpital du Midi for nearly thirty years, Guyon with the Hôpital Necker for more than twenty-five years, and so with other surgeons of note.

Not only is the service continuous in the same hospital, but the amount of time devoted to hospital work is something remarkable to a transatlantic observer. In New York the work is divided up, one surgeon attending to his service there a few months, and succeeded by another; but here the surgeon goes every day and devotes three or four hours, practically the entire forenoon, to his work. To one familiar with the conditions of professional success in our country it is a source of surprise how many physicians here manage to live with such a modicum of time devoted to their private practice.

The hospitals which have most interested me are the Hôpital St. Louis, devoted to the treatment of diseases of the skin, and its out-door department, where hundreds of gratuitous consultations are given daily; the Hôpital du Midi, for male syphilitics; the Hôpital Lourcine, for female syphilitics, and the Necker Hospital with its special service for diseases of the genito-urinary organs.

First and foremost must be ranked the Hôpital St. Louis—the Mecca of dermatologists—with its distinguished corps of attending physicians, Fournier, Vidal, Besnier, Hallopeau, Pean, and others; its magnificent museum, where the student will find reproduced in wax with the most marvelous fidelity the ordinary as well as the rare and curious forms of skin disease, syphilitic, surgical and pathological specimens, etc. These reproductions, executed by the masterly hand of M. Baretta, whose artistic abilities and long experience have enabled him to portray every outline, tint and shade of disease in the most realistic manner, are better for purposes of instruction than any atlas of skin diseases, better indeed in their variety and completeness than bedside studies.

I have been greatly interested in the service of M. Vidal, especially in the observation of his method of treating lupus. Every Thursday he operates on from forty to seventy-five patients, illustrating every variety of lupus. I had supposed that lupus must be much more common in Paris than in New York, until I learned that lupus patients came from all over France to be treated by Vidal.

The results of his treatment are most satisfactory—in some cases most surprising. Faces marred and rendered unsightly by these hideous reddish patches of disfigurement are in a few weeks by his method of treatment made smooth and white, with scarcely a trace of the original disease. His method of treatment is by multiple scarifications. The incisions are made with a single blade, the multiple scarificator having been abandoned. The entire area of diseased tissue is rapidly gone over by numerous parallel incisions closely approximated, and these crossed at right angles or diametrically by other incisions, their depth being regulated by the character of the lupus. The bleeding is checked by compresses of absorbent cotton, the surface sprayed with a solution of the bichloride (1 to 2,000 or 4,000) and afterward dressed with the emplastrum de vigo or red cinnabar plaster (1 to 20).

The other method of treating lupus in vogue at the St. Louis is that of M. Besnier, which consists of multiple punctures closely studding the diseased surface, or linear scarifications with the galvano-cautery. Vidal prefers his method of multiple scarifications, as affording a better cicatrix. The scars are more superficial, more supple, and not so apt to be the seat of keloid. Still, he occasionally employs the galvano-cautery. His treatment is applicable to seborrhœa, acne rosacea, lupoid acne, keloid, and many

other conditions characterized by vascular and connective tissue proliferations.

Vidal makes a distinction between lupus and tuberculosis cutis. For the latter he employs injections of iodoform in eucalyptus.

In France at the present time the various methods of treating syphilis by hypodermic injections are the order of the day. There is a great diversity of opinion as to the relative merits of hypodermic and other modes of administering mercury. Besnier has experimented largely with the hypodermic method at the St. Louis and has practically abandoned it. At the Hôpital du Midi and the Lourcine the subcutaneous method is still largely used. Du Castel at the Hôpital du Midi employs injections of calomel suspended in oil of vaseline; each syringeful represents 10 centigrams of calomel; one-half this quantity is employed the first time and the entire quantity is injected at each subsequent sitting, which should be at intervals of eight days. The injection is carried down deep into the muscles of the buttocks. Considerable pain is experienced from a few hours to three or four days after the injection; abscesses rarely occur; nodules and phlegmons, sometimes large and brawny, may be felt at the seat of the injection. Balzer employs at the Lourcine the yellow oxide (ten centigrams to 1 gram of oil of vaseline), the mercury being perfectly pure and washed several times in boiling alcohol. These injections are repeated every ten to fourteen days. It is claimed that syphilitic manifestations disappear more rapidly and are less liable to recur under this plan of treatment. I have observed quite a number of cases in which this treatment was of doubtful value. I saw two patients who had developed stomatitis, one quite severe, after the second injection, and several cases proved absolutely refractory, the lesions persisting, notwithstanding the long-continued use of the injections. Balzer and Du Castel regard this method essentially tentative as yet. Martineau at the Lourcine is quite enthusiastic over his method by the use of the ammonio-peptonate of mercury. He assured me that its superior value had been established by his treatment of over 6,000 patients in whom he had made over 200,000 injections. These injections are very painful and are employed every day as a rule. I saw Smirnoff, the distinguished Russian advocate of the hypodermic treatment of syphilis, with Mauriac, at the Hôpital du Midi. His method of making the injections differs somewhat from that employed by the surgeons here.

From quite an extended personal observation of the results of the hypodermic method, my own impression is that it will never supplant the older and more classic modes of introducing mercury into the system. Its alleged advantages of accuracy and precision of dose, rapidity of action, avoidance of stomatitis, while securing the maximum benefit from a minimum quantity of mercury, are still *sub judice*.

On Sunday last I dined with Fournier at his charming country place in the suburbs of Paris. In the course of conversation, I took occasion to ask his opinion as to the merits of the method in question. While conceding its possible advantages in certain exceptional cases, he does not employ it. "My advice is that it is not a good treatment. You must give your patients a treatment which will please, or, at least, not displease them. The injections are painful, they interfere with the patient's avocation, they necessitate frequently repeated visits. Above all, the method is not practicable. In private practice patients will not tolerate it. In hospital practice it is possible, but note

the result : Patients leave the Du Midi and Lourcine, where this treatment is employed, and flock to the St. Louis, where they know they will not receive it."

Fournier's service at the St. Louis presented many interesting cases. I was surprised at the frequency of extra-genital chancre. Among a large number variously situated, I noted a double chancre of the lips and chin, both lesions elevated and enormously hypertrophied, an immense chancre of upper surface of abdomen, 9 x 5 centimetres in extent, with characteristic induration of the right axillary glands.

Mauriac showed me at the Du Midi a large chancre of the upper and outer portion of the right thigh, 8 x 5 centimetres in extent, a chancre on the back of the shoulder, and in one patient three large chancres over the hypogastrium, the lesions all of large size and touching at their periphery.

A most remarkable thing is, that among several hundred cases of syphilis I have seen but two cases of chaneroid in the hospitals here. Mauriac says, "Soft chancre is practically extinct at Paris at present. We get only one chaneroid to fifteen or twenty indurated chancres." The exceeding variation in the proportion of chancres and chaneroids from year to year is one of the most interesting features in the natural history of venereal diseases. A correct interpretation of this clinical phenomenon no doubt has an important bearing upon the origin and nature of the soft sore. In Charity Hospital we are accustomed to see four or five chaneroids to one chancre, while in private practice the proportion is reversed.

In passing I may say one word in regard to the treatment of blenorrhagia. Balzer employs for vaginitis, tampons soaked in a saturated solution of salol in olive oil. He has been experimenting with this treatment for some time, and gets satisfactory results. Du Castel employs resorcin almost exclusively as the basis of his injections in gonorrhœa. The injections are used in the acute stage for chronic urethritis. Instillations of nitrate of silver in the deep urethra are employed as with us.

The Genito-Urinary Surgeon Guyon's service at the Necker Hospital furnishes a most interesting field for observation and study. His museum contains an immense number of pathological specimens representing every known lesion of the genito-urinary tract, with an enormous collection of calculi of every variety, form and size. One could spend days with advantage in studying these specimens.

I saw him perform numerous operations, but want of space will permit me to refer to only two or three.

Like other surgeons in France he always employs the instrument of Maisonneuve, which cuts from before backwards, in performing internal urethrotomy.

An external perineal urethrotomy for impassible stricture which he did on July 9th merits a more detailed description, since it has all the interest of a new operation. After the stricture had been divided and the sonde à demeure introduced into the bladder, the internal urethral wound was immediately united by twelve silk-worm sutures. The external wound, after being thoroughly dusted with iodoform, was closed by silk and six silver sutures and a drainage tube introduced at its posterior angle. A week later the silver sutures were removed and the external wound was found to be firmly united in its entire extent, except at lower portion ; the drainage tube was removed.

This was the first time M. Guyon had ever attempted to close a

perineal wound by immediate suture and the result of the operation was eminently satisfactory.

Another operation which greatly interested me was the removal of a vesical tumor by supra-pubic cystotomy (*taille hypogastrique*). I cannot speak too highly of the admirable precision and accuracy with which the tumor was located before the operation was done.

The earlier steps of the operation differed in no essential particular from the procedure described by Dr. Keyes in the July number of this JOURNAL. A large fungoid mass was found occupying the left lateral half of the bladder. The mass was broken up and partly pulled away by the fingers. Additional masses were removed by the galvano ecraseur and the pedicle treated in the same way. Numerous small pedunculated pea-sized tumors were removed by the forceps and the mucous surface of the bladder thoroughly curetted. The entire surface was then treated by the Paquelin cautery.

The wound of the bladder was partly closed by sutures—two above and two below—leaving sufficient space in the middle for the insertion of the drainage tubes.

I called Guyon's attention to the suggestion made by Keyes for perineal drainage, the necessity for which he distinctly disavowed. "Why," says he, "make another wound? Infiltration of urine is not possible if my method of drainage is practiced. In all my operations I have never had infiltration but once—my second case—and that was before I perfected my method of drainage."

The patient rallied well from the operation and was doing well at my next visit, four days later.

I have witnessed two or three operations of this surgeon for crushing stone, but the steps of the operation are too familiar to my readers to be detailed here. The evacuating tube which he employs differs in some respects from that in use in America.

P. A. M.

PARIS, July 22d.

DERMATOLOGY AND KINDRED STUDIES IN GERMANY.

Parasitic Sycosis in Hungary.

S. RÓNA says in the *Pester Med. Chir. Presse*, 1887, No. 18, that parasitic sycosis, as an abortive process of herpes tonsurans, is infrequent in many countries, and this is also the case in Hungary. He observed this affection in a street-sweeper, and describes how it can be distinguished from sycosis vulgaris, acne vulgaris, and furunculosis, in the following manner: The nostrils, the upper lip and the chin were covered with crusts and pustules, and the chin moreover was covered with nodes.

Both small and large hairs pierce the nodes and pustules, between which may be found nodes and nodules free from hair. Upon the neck and left side of the face furuncles were also present. Thick hairs are less frequently met with. They are difficult to epilate and show upon their roots a layer of pus, and a drop of blood appears at the point from which the hair is extracted. The thin hairs, which are more numerous, appear as though broken off on their free end, and may be epilated with ease. These show a knotty hair root. Microscopically there may be observed in the thick hairs hardly any micro-organisms excepting such as are peculiar to the pustular

condition of the root. The thin ones, on the other hand, show an abundance of mycelium and spores. The thrapy consists in epilation, opening the nodes and pustules with the sharp point of a knife and washing with a sublimate solution of 1 to 1,000, and the subsequent application of a 5 per cent. salicylic plaster.

Erysipelas.

Clossen treats of the thrapy of erysipelas according to Kraske (*Centralb. für Chir.*, 1877, No. 19). He made incisions from six to eight centimetres long around the edge of a patch of erysipelas in such a manner that half the length of the incision was in the healthy skin and the other half in the erysipelas patch, and these incisions were crossed by others at a sharp angle so that the diseased area was inclosed in a net of incisions. Upon the borders of the patch rings appear which mark the limits of the erysipelas.

A bandage saturated with a sublimate solution (1 to 1,000) is applied three times daily. This treatment is not applicable to erysipelas of the face, for scars might result. As a method of treatment for the entire area of a patch it is, however, especially applicable to cases with very deep infiltration.

Often by the day after the application has been made the patches begin to whiten.

Transmission of Lepra to Rabbits.

Dr. F. Wesener (*Münchner Med. Wochens.* Nos. 16, 17, 18, 1887) came into the possession of a few pieces of leprous skin from the person a twelve-and-a-half-year-old girl, a patient in the Elizabeth Hospital of Berlin. The dry pieces were inoculated into the abdominal cavity of one rabbit and into the orbital cavity of another; both animals died after seven months. The one inoculated in the abdominal cavity gave a negative result and the one inoculated in the eye showed very considerable changes in the form of cloudiness, spots and infiltrations in the iris and swellings of the cornea. Histologically the cloudy spots showed a grouping of round cells and in the round cells a few bacilli were to be seen, besides pigment flakes which, according to the author, indicated that the bacilli, acting as foreign bodies, caused the collection of the round cells to form, which collections the bacilli eventually caused to break down.

A second series of experiments were made by injecting the pieces of skin in a solution in salt. Six animals were injected, in the peritoneal cavity, the eye cavity, the jugular vein and the cavity of the cranium and subcutaneous connective tissue.

In four cases the results were negative, while in the remaining two, nodes and nodules were found in the lungs, liver, spleen and kidneys. The nodules, which were circumscribed, of a yellow color, and consisted of epithelial cells, became affected with cheesy degeneration. The author regards these processes as tubercular, and concludes that inoculation of lepra in animals has not as yet been successful and that those cases which appear to be so are in reality cases of tuberculosis.

The Etiology of Multiple Abscesses of the Skin in Infancy.

Dr. Th. Escherich (*Münsch. Med. Wochensch.*, 1886, Nos. 51-52) concludes as the result of his bacteriological researches that the affection of child-

hood which has been known by the name of dermatitis folliculosa or phlegmonosa is not the result of a general dyscrasia, but of a genuine parasitic affection of the skin. The disease is characterized by the appearance of multiple abscesses distributed in the subcutaneous cellular tissue. In the beginning a movable and apparently painless nodule is observed which, after obtaining its full growth, suppurates and finally bursts through the skin. Strong as well as weakly children are affected with this trouble. The lesions are mostly situated in the region of the anus, the back, neck and back of head, and occasionally upon the lower portions of the legs.

The differential diagnosis is important, distinction being made between this affection and syphilis, cold abscess, tuberculosis and scrofulosis.

Examination of the pus and the diseased tissue showed cocci (*staphylococcus pyogenes albus et aureus*).

The mode of entrance of the infection is often through the medium of swaddling clothes, which often contain the germs, entrance being gained through the openings of the glands of the skin where the skin is macerated.

The treatment consists in opening the abscesses and washing them out with antiseptic solutions and paying attention to the cleanliness of the child's clothing.

Dermatitis Acuta Produced by Impure Lanoline.

Dr. G. Meyer (*Deutsche Med. Wochensch.* No. 19, 1887) says one must use a good article of lanoline, else the patient may have an artificial inflammation of the skin produced. The writer's case demonstrates this. A man with swollen testicle was given an iodide of potassium ointment made with lanoline to apply. After making four applications an enormous swelling of the scrotum and penis took place. Upon using a pure preparation the swelling disappeared, but was produced for a second time by again returning to the impure preparation. Impure woolfats contain a very dangerous and irritating substance, and their use should be guarded against.

VIENNA.

HOROVITZ.

THE THERAPEUTICAL VALUE OF THE MORE RECENT ADDITIONS TO THE GENITO-URINARY PHARMACOPŒIA.

In a lecture by Mr. E. Hurry Fenwick before the students of St. Peter's Hospital for Urinary Diseases, in London, he began his observations by referring to the changes which had been introduced or had forced their way into our therapeutical practice of late years and pointed out how much more had been done abroad in this direction than could be boasted of in this country, although here in England we were in some respects exceptionally well situated for the acquirement of new materials to work upon, and for the means of experimental study. He would not detain them, he said, by any lengthened description of the properties of those drugs of which specimens were on the table, as such descriptions had been published elsewhere and were probably familiar to most of those present. His present object was rather to encourage students to think, experiment and record for themselves, as he wished to bring before them prominently some of the properties of a few comparatively new drugs which had not hitherto been published, or had received less attention than they merited. We give a brief account of the more novel portions of Mr. Fenwick's observations:

Coca.—The lecturer succinctly narrated the properties, so long known throughout South America, possessed by the leaves of the erythroxylon coca, the isolation of its active principle cocaine, and especially the discovery by Koller of its now well-known power of producing local anæsthesia, which is one of the most distinctive characteristics of the alkaloid just named. The enormous, and in some senses hitherto unsuspected, value of cocaine in diseases of the bladder and generative organs, as well as for the relief of headache, and neuralgia of the fifth pair of nerves which both quinine and gelsemium seemed powerless to touch, was especially impressed upon the students by the clinical records of various cases treated under the lecturer's personal observation. A 20 per cent. solution of the hydrochlorate was the form he generally preferred. Amongst the cases mentioned in illustrations was that of a man who came to him almost doubled up with pain, having just passed a small stone, and being apprehensive of the presence of another. Mr. Fenwick was enabled to give immediate relief by merely injecting into the urethra a few minims of the cocaine solution, when the pains "ceased almost as if by magic," and the man went on his way rejoicing.

Kola.—The great importance of kola paste as a mild stimulant in cases of depressed vital force was illustrated by various cases.

Salix Nigra.—Mr. Fenwick has found that the tincture, administered pretty frequently in 5 m. doses, is of the utmost value in the treatment of gonorrhœa, gleet, etc., the character of the discharge speedily altering and the burning sensation passing off more rapidly than with any other mode of treatment.

Kava Kava.—In urethritis, cystitis and gonorrhœa better results are obtained with the kava extract than with either cubebæ, copaiba, or sandal wood oil, and the new remedy is pleasanter to take.

Strophanthus.—After giving a short account of Professor Fraser's researches, the lecturer proceeded to show that strophanthus is not only a cardiac stimulant, and diuretic in the senses hitherto understood, but that it is capable of saving life in cases of collapse after operation for cystitis, etc. Cases were cited in illustration.

Pinus Sylvestris.—With this, in the form of a thick extract of a strong consistence, the lecturer had effected cures in many cases of gonorrhœa where copaiba was found to be incapable of producing the slightest beneficial effect.

Lycopodium.—The lecturer states that for enuresis, whether suddenly developed as the result of accident or operation, or in cases where the incontinence of urine had been of several years' standing, he was acquainted with no drug which gave such entirely satisfactory results as the tincture of white lycopodium. He had first employed it to check the nocturnal enuresis of children, but finding it so surprisingly successful, he next employed it for adults with the result that micturition was quickly reduced from six or eight times an hour to once in two hours. He regretted that the drug was so expensive at present. Next in efficacy to the tincture he placed the preparation of the white powder, but warned his hearers that the yellow or brownish-yellow kinds of lycopodium in the market were, for this purpose, practically useless and inert. The lecture was illustrated with specimens, experiments and the recorded data of cases, and was noteworthy as marking a distinct innovation in the annals of the British schools of medicine.

PARACELSUS.

Selections.

ETIOLOGY AND THERAPY OF IMPETIGO, FURUNCLE AND SYCOSIS.

DR. BOCKHART (*Monatsh. f. Prakt. Dermat.*, 1887, No. 10) is of the opinion that impetigo (Wilson) must be regarded as an independent disease, since in a series of cases (22) the staphylococcus pyogenes aureus and albus could always be found in the pus, and that, furthermore, by repeated inoculations of a pure culture eruptions of clinical impetigo could be produced.

Again in the pus of furuncles which appeared in his patients with impetigo and also in the impetigo which had been experimentally produced he met with the same staphylococcus. He therefore refers both affections to the same pathological process, and the staphylococcus pyogenes aureus and albus. And not only did he find them in these two skin diseases, but also in a third attended with purulent inflammation whose etiology has been unknown—namely, sycosis.

In a patient who has sycosis of the upper lip and chronic nasal catarrh the author found the staphylococcus in abundance in the mucus of the nose.

In treating these diseases, therefore, attention should be paid

1. To assisting nature in her efforts to effect a cure.

2. To preventing the now known cause of the disease from acting a second time upon an individual once affected, and especially to guard against recurrences of the disease by prophylactic measures.

The pus cocci which have penetrated the skin, the hair follicles, the sebaceous and sudoriporous glands will be removed from the organism by the white blood corpuscles. Healing here takes place by suppuration. We must here assist nature in her efforts to eliminate the pus cocci from the skin. This we can best do by promoting the discharge of the pus. Antiseptics must assist. By the suitable employment of antiseptics we can prevent the pus cocci from infecting anew the once cured organism.

This plan can be well carried out if the cocci have not penetrated the skin deeply, as in impetigo. This disease, indeed, gets well comparatively soon of itself, but we can hasten the cure if we open the pustules and disinfect them.

Besides, by this mode of treatment the development of a furuncle out of an impetigo pustule is best prevented. As a disinfectant the author employs by preference a one to two per cent. sublimate solution. Unless they are disinfected the pustules once emptied soon fill again.

In treating sycosis the author uses the sublimate solution after epilation. In this way cure was brought about in several obstinate cases of sycosis. To prevent recurrences it is advised to wash the face once or twice daily with a one per cent. sublimate solution. If the patients neglect this for a time sycosis nodes or pustules again appear.

In treating boils the antiseptic washes are not of much use. Carbolic compresses may be applied, but the carbolic acid cannot penetrate to the deeper parts. Injections of antiseptic solutions into the furuncle itself or into its neighborhood are unbearably painful and of little benefit. We must, therefore, content ourselves with the older methods: Warm applications, emplast hydrarg., incision, etc. To prevent recurrences antiseptics can scarcely be employed here, but sublimate baths can be taken.—JARISCH in *Centralb. f. Therapie*, July, 1887.

A NEW TREATMENT FOR OBSTINATELY RECURRING ECZEMA.

DR. H. RADCLIFFE CROCKER (*British Med. Journal*, July 8, 1887) believes that many cases of eczema, in which a fresh outbreak occurs again and again, just as we think we have succeeded in effecting a cure, and which become so disheartening to patient and physician alike, are due to a vaso-motor neurosis.

He proposes a method of treatment by counter-irritation over the vaso-motor centres, and gives a number of cases in which he has succeeded in giving relief when other treatment has failed. In the first case in which he was induced to try the method, he painted liq. epispasticus on the nape of the neck, and although a fresh attack was threatening it did not come on, and the patient felt better. Three days later, the part having healed, the blister was repeated, and there was evident improvement after it; the scales were less and the irritation was much relieved. The rash threatening again, another blister was produced. This, however, did not stop the rash, which came out freely, but the itching was much less than usual, and the eruption lasted but a short time, and from that time the patient continued to improve and was able to go to work for five months, but having to keep his hands much in water it then returned. Encouraged by this result in a very unpromising case, the author extended the treatment, but using milder counter-irritants, such as mustard plasters, or mustard leaves, instead of blisters, which were unnecessarily severe.

In a case of eczema of the scrotum which had lasted for some weeks, where the irritation was as usual very severe, mustard leaves over the lumbar enlargement, rest, and a little olive oil smeared on to prevent the parts sticking to the bed-clothes, were the only means employed; relief to the distressing itching was at once afforded, and the patient got quite well without any other treatment.

The position of the counter-irritant is to be varied according to the region affected; thus, for the face alone, it is placed behind the ears; for face and forearms, on the nape; about the genitals or legs, over the lumbar enlargement; and if one leg only is affected, on the hip over the large sciatic nerve.

The result has been more or less beneficial in the great majority of cases. It has seldom failed to relieve the itching, and generally procured sleep, at least on the night of application, and often the alleviation has lasted for several nights. In many cases the redness and swelling have also subsided sometimes entirely, sometimes in great measure, and generally enough to make it more amenable to local treatment than it was before.

In none of the cases was an eczema excited on the site or neighborhood of the counter-irritant, even when applied on an already eczematous surface; and often, in such cases, the eczema cleared off all round the site of the mustard; although, as might be expected, no benefit was obtained in a few cases, in none was the disease aggravated; at the same time, it is very probable that, if repeated too frequently, and at too short intervals, in some cases there might be increased irritation. In a case of general psoriasis, in which the treatment was tried, strips of mustard leaf were put on all down the spine. In the next three days there was distinct improvement, less redness and less scaling; it was repeated three nights later, and this time the eruption went back to its original condition; the treatment was not continued.

One advantage of this method is that it does not interfere in any way

with other treatment, whether internal or external, and that it is safe ; but inasmuch as there is a natural shrinking from irritants on the part of an eczema patient, it may be more prudent in some cases to begin with dry heat, such as a hot tile wrapped in flannel, and if sufficient relief is not obtained, to go on to stronger applications.

ABSORPTION THROUGH THE SKIN.

As is well known Liebrich believed that he had found in Lanolin a substance which possessed superior powers of penetration through the skin.

Ritter has found in his experiments (*Rundschau*, July 15, 1887) that it does not manifest any noticeable superiority over lard when used as an ointment base with such substances as iodide of potassium, salicylic acid and salicylate of sodium. The first two drugs when rubbed into the skin in the form of an ointment are absorbed and can be detected in the urine, but salicylate of sodium always gave negative results. Other experiments made to test the capability of the skin to absorb substances sprayed upon it in watery solution gave negative results.

VARICELLA.

VARICELLA is usually considered a mild affection requiring little attention, but Dr. Comby has shown in the *Rev. Mens. des Mal. de l'Enfance*, April, 1887, that it is not always so benign, and its diagnosis not always easy.

The conclusions presented by the author are:

1. A bucco-pharyngeal examthem is almost constantly found early, and if the vesicles are discrete no marked inflammatory reaction takes place. If abundant, a severe stomatitis, gingivitis or an inflammation of the lips may result.

When severe, the stomatitis of varicella produces salivation, swelling and pain. The vesicles may appear upon the conjunctiva and conjunctivitis result. The cornea may even be affected and permanent marks be left. Vulvitis with painful urination may be produced in female children by varicella.

The complications are not severe aside from those in which the cornea is involved, and those on the part of the kidneys occasionally resulting in nephritis and albuminuria.

2. The differential diagnosis between varicella and variola rests entirely upon the recognition of the vesicles of variola, which is typical. The disease should not be confounded with vesicular urticaria or pemphigus.

THE FUNCTION OF THE URETERS.

DR. SAMSCHIN (*Centralbl. f. Gynäk.*, No. 19, 1887) after referring to observations made by others in cases of exstrophy of the bladder and vesicovaginal fistula, reports his own observations in a case presenting a large recto-vesico-vaginal fistula, in which, with the aid of a speculum, he was able to bring the openings of the ureters plainly into view. His conclusions are as follows :

1. Contraction of the ureters takes place in both man and the lower animals in a peristaltic manner. Each contraction results in the discharge of a variable quantity of urine.

2. The contractions at the vesicle orifices of the ureters do not take place synchronously.

3. The number of contractions observed at the orifice of a ureter in a given time is not constant, but is found to vary with each observation.

4. The total quantity of urine discharged by each ureter in a given time varies, as well as the average quantity discharged by each in a single contraction: the latter quantity varies between 8 and 2 ccm.

5. The maximum of quantity discharged by a single contraction amounted to 4 ccm.

6. No increase in the number of contractions was observed to take place after the copious injection of fluids.

TREATMENT OF PEMPHIGUS

ACCORDING to Dr. Chambard pemphigus should be treated in the same manner as a burn. If the bullæ are intact they should be punctured with a needle and the greater part of the liquid contents allowed to escape, the derma being carefully protected. A poultice must be applied and left on from twelve to twenty-four hours, after which it should be replaced by cotton wool which is to be left on until the parts are quite healed. Hebra says that hydropathy has proved successful in some cases. In acute pemphigus sulphate of quinine should be given, and in the case of a robust patient blood letting may be beneficial. In chronic pemphigus tonic treatment is indicated; iron, bark, arsenic and strychnine giving excellent results.—*British Medical Journal*, July 9, 1887.

LOCAL APPLICATIONS TO THE PROSTATE GLAND.

DR. WILLIAMS (*The Therapeutic Gazette*, June 15, 1887) says enlargement of the prostate is a disease almost peculiar to middle and advanced life, but chronic irritability and inflammation are much more frequently met with between the ages of twenty-five and fifty. In all chronic urinary troubles a digital examination of the prostate should be made.

The origin of more than half the cases of prostatic disease treated by the author has been a neglected or improperly treated gonorrhœa. Chronic enlargement of the prostate may be a simple increase in the size of the gland from previous congestion due to frequent or long-continued sexual excitement or previous inflammation. It may arise from serofulous or tubercular deposits, from calcareous deposits in its substance, and finally from a new growth.

Each form of enlargement is denoted by characteristics which enable us to diagnose them accurately. A simple hypertrophy, which usually affects the lateral lobes, may reach enormous proportions without giving rise to any particular symptoms. If the middle lobe forming the floor of the prostatic portion of the urethra, or that portion next to the bladder is only slightly enlarged, difficulty of micturition is sure to follow.

The early symptoms of enlargement are: difficulty of emptying the bladder, a frequent desire to pass water, especially at night and in the morning. There may be slight pain before passing urine, but not afterward. These symptoms increase in severity as the enlargement progresses. The desire to urinate becomes imperative. The urine accumulates and distends the bladder. Cystitis is liable to occur.

Those suffering from chronic hypertrophy are liable to have attacks of congestion of the prostate with complete retention, bloody urine, increased temperature, etc. Unless relief is obtained by the catheter the patient sinks into a typhoid condition which may end fatally. Old men are more liable to these attacks. If residual urine remains in the bladder, the patient should be taught to use the catheter, else the bladder will never be emptied.

Along with the local such general treatment should be instituted as the case may require. Great relief and benefit will be experienced from the use of suppositories, properly medicated, as with iodide of potassium, iodoform, belladonna, etc.

The symptoms of chronic prostatitis, which resemble those of stone in the bladder so closely that mistakes may occur, are: a frequent desire to urinate, with a feeling of weight and heat in the perineum, and a pain extending the whole length of the passage to the tip of the penis. A few drops of blood will follow the urine, and generally the patients suffer from nocturnal emissions. The urine is cloudy and shows a muco-purulent deposit on standing.

The prostate is tender to the touch and enlarged. The condition gradually subsides into a mild but persistent chronic form, the gland remaining engorged and irritable. The urine feels hot, attended with a smarting or stinging sensation after passing. A still more frequent symptom of this hyperæsthesia of the prostate is the oozing out of a thin, transparent discharge, which is increased by any sexual excitement. This discharge is composed mostly of prostatic mucus. Seminal fluid may be mixed with it after prolonged sexual excitement, especially if ungratified, and this condition furnished one of the principal causes of chronic hyperæsthesia of the prostate. During erotic excitement the gland becomes congested, the copious plexus of veins which surround it communicate freely with those of the vesiculæ seminales, penis and testicles, and connect not only with the systemic but also with the portal circulation. In cases following chronic gonorrhœa the discharge assumes a gleet character; only a drop may be detected in the morning, but the quantity may be so increased after any exercise as to resemble a regular case of gonorrhœa.

TREATMENT BY LOCAL APPLICATION, made directly to the prostatic portion of the urethra, has given the best results in the author's hands, and he believes that the almost incredible results claimed by Lallemande for the *porte caustique* in spermatorrhœa and impotence were due more to the direct antiphlogistic action exerted upon the prostate than to any special effects of the cantery upon the spermatic ducts. Very few cases in the author's experience require caustic applications. In the greater number he has found alterative and sedative applications such as hydrarg. bichlor., iodoform, belladonna, ergotin and cocaine meet every indication. The particular agent chosen must be governed by the pathological condition of the gland as developed by digital examination in each separate case.

Whatever remedy is indicated should be applied in the form of an ointment, as comminution renders absorption easier.

He employs the *porte caustique* of Lallemande, charging the cup of the projecting part with the ointment instead of the nitrate of silver. Passing the canula down the passage to the prostatic portion of the urethra, the cup containing the ointment is projected and allowed to remain for about five minutes before withdrawing. The operation causes no suffering, and may be re-

peated once a week, sometimes twice, and it is seldom necessary to continue them longer than from six to twelve weeks. Ergot applied in this way to the prostate is effectual in cases of impotence due to the want of erectile power. Impotency in middle life, in the writer's experience, is oftener due to disease of the prostate than to failure of the generative functions.

In closing, the author says, *whenever any trouble is experienced in passing water for any considerable length of time, suspect disease of the prostate gland.*

GIANT URTICARIA AND INTERNAL URTICARIA.

DR. RAPIN concludes a paper (*Rev. Med. de la Suisse Rom.* No. 12, 1886) based upon the study of eighteen cases, as follows :

"Among the various forms of urticaria, there is one remarkable from the considerable dimensions of its patches, which has received the name of giant urticaria. The eruption may be limited to one or two patches, affecting, usually, certain special regions, as the hands, forehead, neck, etc. Itchiness, which is regarded in general as inseparable from every urticarial eruption, is sometimes absent. The œdema of neuropathic origin which constitutes urticaria, scarcely pits, and retains but imperfectly the impression of the finger. The absence of these two characters, itchiness and pitting, have, therefore, no absolute value in the diagnosis of urticaria.

"Urticaria is often internal and has for its seat the mucous membrane of the digestive canal in any part from the mouth to the intestine. The proofs of this localization are furnished us by the swelling of the tongue and pharynx, the seat of pain in the course of the œsophagus and in the stomach, and finally by the digestive disturbances, eructations, vomiting, diarrhœa. The existence of urticaria in the bronchi is not considered to have been proved. Urticaria and migraine seem to be related as to their origin, and belong to the same diathetic stock. The prognosis is not regarded as grave."

While Rapin is familiar with what has been written in France on this subject, he only alludes to Kaposé in Germany, and ignores what Quinke, Laudon and Strübing have said about it.—*Edinburgh Med. Journ.*, June, 1887.

EASY ADMINISTRATION AND EXACT DOSE OF THE IODIDES IN SOLUTION.

To obviate the disagreeable taste of the iodides attempts have been made to administer the salts in the form of pills, capsules, etc. The inconvenience of these preparations has always been that they were not easily preserved, and that thus administered the salts irritated the stomach. In solution the iodides are usually distasteful, even when administered with syrups, in milk, beer, etc. And the "teaspoonful" dose is not always exact. To be sure a saturated solution of the drug, of which a given number of drops are to be taken, furnishes a convenient and accurate method of dosage, especially where increasing doses are desired. Still this has its disadvantages in some cases. M. Warin (*Gazette des Hôpitaux*, June 9, 1887) has succeeded in enclosing in a thin coating of gluten a solution of the iodide of potassium by the process devised by Cornu, forming what he terms *bulles*, each one of which contains about four grains of the salt. The advantages claimed are : that the taste is hidden, the dose is rigorously ex-

act, and the salt in solution is less irritating to the stomach than in its natural state.

Experiments showed that the capsule does not rupture in the stomach, but that the solution gradually passes through its walls by exosmosis.

IMPETIGO CONTAGIOSA IN CHILDREN.

DR. ZIT, of Prague (*Archiv für Kinderh.*, VIII. Band, 1887) considers that the overcrowding of dwellings exerts a great influence upon the origin of impetigo contagiosa. He is in doubt as to whether the character of the soil exerts any influence, but quotes from Beach an account of an epidemic which prevailed in a street which had been built on soil previously a morass. The contagion is most marked when the eruption occurs upon the scalp, and appears to spread among the children using the same comb. He thinks the care of the hair and scalp does not receive the proper attention on the part of the parents and hair-dressers, who should be instructed in this manner of spreading infectious diseases. Premature baldness he believes to be often communicated from person to person by the use of brushes, etc. Unless properly treated impetigo may last for months. In the author's hands 1 to 1,000 corrosive sublimate solution has given good results.

TUBERCULOSIS OF THE SKIN.

PROFESSOR SCHWIMMER (*Viertelj. f. Derm. und Syph.* Heft. I, 1887) does not accept as fully proven that lupus is a local tuberculosis of the skin, and believes that the clinical pictures of the two diseases are quite distinct.

1. Cutaneous tuberculosis is a rarity; lupus is relatively frequent. Tuberculosis rapidly breaks down and lupus nodules are wanting.

2. Tuberculosis is almost exclusively found in mucous membranes at first, and only subsequently extends to the skin. In lupus, the converse is the rule, rarely being found upon a mucous membrane alone.

3. Lupus of the skin rarely leads to general tuberculosis, while tubercle is the index of a constitutional disease.

4. In cutaneous tuberculosis bacilli are much more numerous than in lupus, as numerous, in fact, as in the sputum of phthisis.

The lepra and syphilis bacillus closely resemble that of tubercle, and he questions whether the lupus and tubercle bacilli are identical.

Lupus has not been produced by inoculation from tuberculosis, although it is said that inoculation with lupus tissue has produced tuberculosis. If identical, they should be equally transmissible, the one from the other. In treatment, destructive agents which prove so useful in lupus, do not act so favorably on tuberculosis, which is more benefited by measures which diminish irritation. The pain of the latter disease he has found to be best relieved by papayotin in 5 per cent. solution, which has no effect on lupus.

SYPHILITIC FUNGUS OF THE TESTICLE.

DR. MAURIAC says that the most common cause of fungus of the testicle is the gummy sarcocele, as Professor Gosselin believed, and as Rollet has furnished clinical proofs to substantiate this belief.

There are two varieties of syphilitic fungus of the testicle. The superficial fungus which results from a subserotal gumma, originating either in the subcutaneous cellular tissue, or in the superficial layer of the tunica albu-

ginea; and the deep-seated fungus which almost always comes from a gumma of the testicle (intra-albuginea) which has softened and is being evacuated.

Histologically the two varieties are distinguished by the absence of seminiferous tubules in the fungosities of the first, and their presence in those of the second.

The syphilitic fungus is benign; it must not be confounded with cancer, tuberculosis or the fungus of certain severe orchio-epididymites complicated with abscess of the scrotum. This fungus has no bad prognosis as regards spermatogenesis. Its treatment does not differ from that of syphilitic sarcocele. The temptation to plunge a bistouri into the diseased tissue or to excise or cauterize it must be resisted.—*Annales de Derm. et de Syph.*, July, 1887.

COCAINE IN OPERATION FOR HYDROCELE.

DR. PETIT writes to *Le Concours Médical*, May 21, 1887, that before injecting the following solution into the tunica vaginalis :

R Tinct. Iodin. Recent.....	45 grams.
Potass. Iodid....	2 grams.
Aquæ Destil.....	100 grams.

he first injected

R Cocaine Chlorhydrat	0.15 centig.
Aq. Destil.....	20 grams.

In this way no pain was experienced from the operation.

MOLLIN.

DR. ALFRED KIRSTEN (*Monatshefte für Prakt. Dermat.*, No. 8, 1886 and No. 5, 1887,) describes a new substance, which he calls mollinum, and presents it as a vehicle for cutaneous medicaments. It was first prepared by Theodor Canz, a druggist of Leipsic. It is a soapy substance, prepared by the following formula :

Fat, 100 parts; lye 40 parts (principally potash and a little soda lye). When saponification has taken place it is reduced to the consistency of an ointment by warming with 30 per cent. of glycerine.

Mollin is of a dull white color, and the advantages claimed for it are, that it is neutral in reaction, stable in consistence, misirritating, mixes readily with various medicaments, permits of even and thorough application, and is readily washed from the skin. Its superiority over soaps lies in the application being made without the use of water.

It is said to be more readily absorbed by the skin than vaseline or lanoline and hence of great value as a base for the various mercurial ointments.

Its non-liquefiable nature makes mollin-hydrarg. especially desirable for export to hot climates. And Dr. Kirsten thinks it is calculated to oust the gray ointment altogether, being more cleanly and of more positive effect.

Combined with styrax or tar for the treatment of scabies, etc., it acts well and can be readily washed from the skin which surely is an advantage.

Preparations of mollin are made with carbolic and salicylic acids, 3-5 per cent., balsam of pru., ichthyol, iodoform, iodide of potash, styrax and naphthaline, 10 per cent.; chrysarobin, naphthol and phymol, 5 per cent.;

sulphur, 30-50 per cent.; corrosive sublimate, 1 per cent., and hydrarg., cinereum in any strength desired.

In his last-mentioned article, the author advocates the substitution of mollin preparations for the usually employed iodine and iodide of potassium ointments.

Liebreich (*Therapeut. Monatshefte*, Heft 4) says of mollin that it may be easily made with cocoanut oil which saponifies easily when cold and brings about saponification in other fats mixed with it. He gives the following formula for its preparation : Cocoanut oil and lard each fifty parts are mixed together and treated with a solution of caustic potash twenty parts, to four parts of water, and allowed to stand for an hour, when saponification takes place. To this compound is added 17 per cent. of fat previously melted and refined. Glycerine may also be added.

Mollin, he says, is a cocoanut oil potassium soap in which the free alkali is not entirely neutralized, but whose action is much lessened by the excess of fat. The lower fatty acids apt to be present in cocoa fat may produce an irritation of the skin, and this fact should lead to caution in preparing mollin and employing it upon the skin. He suggests the substitution of lanoline for the cocoa fat to avoid any danger of the substance becoming rancid, and offers as a useful substitute :

Saponis kalini (Germ. Pharm.).....	100 parts.
Adipis (melted at gentle heat)	50 to 80 parts.
Glycerine.....	10 parts.

SPURIOUS VENEREAL DISEASES.

DR. LLOYD says in a recent number of the *Birmingham Med. Review* that spurious venereal diseases occur in both sexes. The majority of the author's private cases of urethral disease are not regarded by him as due to direct contagion from a pre-existing gonorrhœa. The symptoms of these cases, however, resemble those of ordinary gonorrhœa, and similar remedies are demanded.

The majority of soft sores result from pre-existing chaneroids, but sores indistinguishable from true chaneroids either by their appearance or their contagiousness, appear on the penis from other causes.

He regards individual predisposition as a potent factor in the etiology of venereal diseases.

The following conclusions are drawn :

1. That a large number of urethral discharges in the male, although sexual in their origin, are not specific.
2. That many penile sores of sexual origin are neither chaneres nor chaneroids.
3. That idiosynersy plays an important part in the contraction of venereal diseases of all kinds.

SYPHILIS AND TABES DORSALIS.

DR. NÆGELI, of Zurich, has looked up the histories of 1,403 cases of tabes and found 36 per cent. of them positively syphilitic and 60 per cent. probably so, counting all suspicious cases. He presents his statistics in an inaugural dissertation in which he shows, that from the cases of Erb, Voigt, Fournier, Althaus and others, 71 per cent. were found syphilitic and 86 per

cent. when suspected cases were included. The cases collected by Gowers, Pusielli and Bernhardt show a mean average of from 50 to 60 per cent.

Syphilis must, according to this showing, occupy an important place in the etiology of tabes.

THE OPERATIVE TREATMENT OF PROSTATIC HYPERTROPHY.

A REMARKABLE case is recorded by Landerer in the *Centralblatt für Chir.*, p. 392, 1887, in which being unable to crush a small stone owing to prostatic hypertrophy he performed the Median operation and extracted two small calculi. During the operation, however, he accidentally removed a small portion of the prostate. The patient made an excellent and rapid recovery and could pass his water subsequently in a good full stream, whereas before he had great difficulty in voiding it. This condition remained permanent fifteen months later. A suggestion is made to perform this operation for relief of enlarged prostate, but the operator has not yet met with a suitable case.—*The Practitioner*, London, July, 1887.

THE LOCAL TREATMENT OF THE BLADDER.

ULZMANN (*Centralblatt für Chirurgie*, No. 30, 1887) says: All acute bladder troubles must be excluded from local treatment which is only applicable to the chronic forms of disease. The acute diseases are recovered from under appropriate diatetic and therapeutic measures. In chronic affections we must discover whether the disease is a primary and isolated one, or whether the neck of the bladder, the deeper portions of the urethra or the prostatic portion is involved.

The latter is the case, for example, in young men who in consequence of a gonorrhœa have begun to suffer from an extension of the disease, and treatment of the neck of the bladder must be carried out.

A thin catheter is first passed into the bladder and then withdrawn about three centimetres so that the point rests in the neck. A tepid medicated solution is thrown in gently (about 200 grams). If no fluid flows back it shows that the end of the catheter is in the right place, the opening being closed by the bladder neck.

After thoroughly injecting the bladder the catheter is withdrawn and the patient empties the bladder himself, and in this way the fluid passes again over the diseased parts.

If, on the other hand, the bladder itself is the part affected the author does not recommend the double catheter because by this method the bladder remains contracted and only a small portion of its mucous membrane comes in contact with the medicated solution employed. He prefers injecting the fluid by means of a hand syringe through a soft catheter.

By the use of the irrigator too great a quantity of solution is permitted to enter which might dilate the bladder, already often in a parietic state, to too great a degree. Only in the rare cases of contracted bladder in young persons is the irrigator to be recommended.

It is further to be looked to that after the injection the bladder is wholly emptied.

For washing out the bladder lukewarm water must be used, medicated with tincture of opium, cocaine $\frac{1}{4}$ per cent., resorcin $\frac{1}{2}$ per cent., or carbolic acid $\frac{1}{6}$ per cent. in case of sensitive bladder; permanganate of potas-

sium $\frac{1}{10}$ per cent. or nitric of amyl three drops to half a pint of water in case of amoniacal urine; $\frac{1}{10}$ per cent. salicylic acid in phosphaturia, etc.

A 1 to 10,000 corrosive sublimate solution may be used when bacteria are present.

For hemorrhage $\frac{1}{10}$ to $\frac{1}{2}$ per cent. nitrate of silver solution in cold water, or fifty to sixty drops of the sesquichloride of iron to the quart of water.

Items.

THE "MONATSHEFTE" INDEX.—We have recently received the index of the fifth volume (1886) of the *Monatshefte für Praktische Dermatologie*, and congratulate the editor, Dr. Unna, upon its fullness and elaboration, comprising, as it does, some seventy-five pages in all. We regret, however, its tardy appearance. Could it accompany or follow closely upon the last number of the volume at the end of the year, it would be very desirable, not only for matter of reference, but also to permit of the volume being bound at once.

P. S.—Since the above was put into print we have been honored with a call from Dr. Unna, who has assured us that the next appearance of the index will not be so late.

MENTHOL AND MENTHOLEATE.—A solution containing from two to ten grains of menthol to the ounce of water has been recommended in urticaria and pruritus. The itching is said to be instantly relieved and repeated applications in many cases effects a cure.

Oleic acid has been found by Professor Remington (*Therapeutic Gazette*) to be a free solvent for menthol and preferable to volatile solvents.

Mentholeate can be made by adding to two hundred grains of menthol in a test tube one-half fluid ounce of oleic acid and applying gentle heat until a solution is obtained.

This preparation will probably be found useful in pruritic skin affections in which a certain degree of absorption is desired.

A CASE OF LUPUSCARCINOMA was reported by Dr. Winternitz in the *Vierteljah. f. Derm. und Syph.*, 1886, Hft. 4, which was seen in the clinic of Professor Pick. The case illustrated how carcinoma may at times spring from or develop upon a lupus base.

With regard to treatment, the author favored repeated cauterization rather than the employment of the knife, in view of the rapid development of the growth.

A RARE CASE OF GONORRHEAL RHEUMATISM is reported by Dr. Fischer, in which a man of twenty suffered from an inflammation of the left radio-carpal joint four weeks after contracting a gonorrhœa, and just as he was recovering from an epididymitis. Salicylic acid was administered to the extent of three hundred grains in the first three days, the patient growing steadily worse. The inflammation reached its height in about ten days and under antiphlogistic treatment was well in about four weeks. The slight

amount of fever, the sudden onset of the affection without warning, its monarticular character, and the ineffectiveness of salicylic acid were the points upon which the diagnosis was founded.—*Centralb. für Klin. Med.*, July 16, 1887.

IODIDE OF POTASSIUM IN PERSISTENT PRIAPISM.—After trying half-drachm doses of the bromide for four days, continual applications of ice for over a week, tartar emetic and morphine, oleate of morphine and other anodynes locally, suppositories, blisters, leaching, and a variety of other methods of treatment without producing any effect upon a priapism in a man aged fifty-five, Dr. Booth finally succeeded in giving relief by the use of five-grain doses of iodide of potassium four times daily.

The condition had lasted for five weeks without any signs of abatement when the iodide was begun. Improvement began at once and in two weeks the patient was well. The priapism was evidently due to local inflammation about the muscles constricting the bulb of the penis.—*Lancet*, May 14, 1887.

INFANTILE HYDROCELE.—In looking over the records of the Hospital for Ruptured and Crippled, Dr. Freeland found that 1,157 cases of infantile hydrocele had been treated in the dispensary department. The treatment by setons, incision and removal of a portion of the tunica vaginalis, etc., has been replaced by milder means, and the results are as good now as they have ever been. Equal parts of tincture of belladonna and compound tincture of iodine, applied twice daily over the hydrocele, constitutes the present treatment, and is generally sufficient to relieve within a week or two, especially if the infant is but a few weeks old. If this fails to cause absorption after a few weeks, the fluid is drawn off by a hypodermic needle or a small trocar. The fluid does not tend to accumulate to the same extent as in the adult.

This treatment is applicable to all forms of hydrocele, congenital, acquired, diffuse and encysted of the cord.—*Med. and Surg. Reporter*, July 2, 1887.

INSANITY AND ERYSIPELAS.—Dr. McKenna records in the *Pittsburg Medical Review*, March, 1887, two cases of chronic mania, cured by erysipelas.

The first was a widow, forty-five years of age, who had been in the asylum for three years, without improving. An attack of facial erysipelas occurred, and she immediately became sane, and was discharged four months later, no relapse having taken place.

The second, a lady of forty-two years, had been insane from an injury to the head, since the age of ten, but had had several intervals of sanity. She was admitted to the asylum, suffering from chronic mania, on June 14, 1884, and remained in a stationary condition until February 7, 1886, when she became immediately sane after an attack of erysipelas of the face. She was discharged two months later.

STRICTURE IN THE NEGRO.—Drs. McIntosh and Carter have arrived at the conclusion that stricture of the urethra, as the result of gonorrhœa, is comparatively rare among full-blooded negroes. Traumatic stricture, in their experience, rare in the white race, is quite common in the negro, nearly half of all cases of stricture met with in the full-blooded negro being traumatic. That gonorrhœa in the negro is milder and more

amenable to treatment than in white men. Their first table shows in 298 cases of gonorrhœa in white men, 68 strictures, or 1 stricture to $4\frac{1}{2}$ gonorrhœas; in 154 cases in the negro race, 12 strictures, or 1 to $12\frac{1}{2}$ cases. Judging from combined statistics, it would appear that a given number of cases of gonorrhœa among the whites will result in three times as many strictures as will the same number in the negro race.

FRECKLES.—The popular preparation known as Perry's Moth and Freckle Cure is said to have the following composition: Bichloride of mercury, 0.72 per cent.; sulphate of zinc, 0.85 per cent. In the sediment were also found small quantities of lead and bismuth.

It is said that several young ladies of Salamanca have had their faces disfigured, and one is in danger of losing an eye, from the use of a freckle remover and complexion *beautifier*. It was sold by a traveling fakir calling himself Dr. McGaw, who has since been arrested. The preparation is thought to be concentrated lye.

Powdered saltpetre, applied carefully to each freckle, previously moistened, is said to be efficacious when perfectly done and judiciously repeated.

The pigment of lentigo resides almost wholly in the epidermis, and although many acids, but preferably a one or two per cent. solution of corrosive sublimate, carefully applied, will remove the spots, they are apt to recur in the summer season.

SYPHILITIC HEADACHE, when violent and obstinate can be relieved in from two to three weeks or less, according to Leroy, by the use of aconitine, in doses of half a milligram, twice daily. *Annal. de Derm. et de Syph.*, February, 1887.

PRICKLY HEAT.—A writer in the *St. Louis Medical and Surgical Journal* says this eruption may be cured in a few days by allowing a two per cent. solution of sulphate of copper to dry upon the skin. Applications to be made morning and night.

FOR PITYRIASIS VERSICOLOR, Besnier advises to first wash the parts with tar soap, and apply each night, for eight days, the following ointment:

℞ Lanoline.	
Vaseline.....	ā ā 50 grams
Salicylic Acid.....	3 "
Precipitated Sulphur.....	10 "

POISON IVY.—A Mr. Blodgett gives in the *Boston Medical and Surgical Journal* June 23, 1887, a graphic description of ivy poisoning in his own person.

Of the various remedies tried, extract of hamamelis had no permanent effect. Solutions of bicarbonate of soda and acetate of lead produced no amelioration. Tincture of lobelia diluted with ten times its bulk of water relieved the itching to a slight extent. His physician then prescribed a 1 to 1000 solution of bichloride of mercury which relieved the itching to a great extent, but the greatest relief was found in bathing alternately with this solution and a weak Indian meal gruel. An alcoholic solution of *Grindelia robusta* did less good.

CARBOLATE OF MERCURY.—Dr. Schadek, of Kieff, according to the *Lancet* of May 7, 1887, has used a preparation named by him “hydrargyrum carbolieum oxydatum” in thirty-five cases of syphilis. It is prepared by precipitating a dilute solution of bichloride with a concentrated alcoholic solution of carbolate of potassium and carefully washing. It was given in doses of $\frac{1}{8}$ gr. and appeared to act well in the macular and tubercular forms of the eruption and in syphilis of the palms and soles.

IODIMS was the subject of the thesis receiving the “Extremely Satisfactory” or highest mark at the recent examinations in the Paris Medical School. The author is Miss Elizabeth C. Bradley, a daughter of Judge Bradley, of New York.

Books and Pamphlets Received.

DAS MOLLIN, ein neues Seifenpräparat als Vehikel für die Kutane Anwendung dermatologischer Medikamente. Von Th. Alfred Kirsten. Leipzig. (Reprint.)

Zwei Neue Mollin Präparate als Ersatz der Jodtinktur und Jodkaliumsalbe. Von Th. Alfred Kirsten. Leipzig. (Reprint.)

Atlas des Maladies de la Peau. Par Silva Araujo. 3d Fasciculus, with plate of Elephantiasis. Leuzinger & Filhos, Rio de Janeiro.

Renal Colic, Parasitic and Calculus. A criticism. By J. V. Marvin, M.D. (Reprint.)

On the Classification of Mental Diseases. By Ralph L. Parsons, M.D. (Reprint.)

Recent Advances in Preventive Medicine. By George H. Rohé, M.D. (Reprint.)

Report on Genito-Urinary Diseases. By E. R. Palmer, M.D. (Reprint.)

Deaths from Gonorrhœa. By Abner Post, M.D. (Reprint.)

Case of Dermatitis Herpetiformis Resembling Erythema Multiforme. By Louis A. Duhring, M.D. (Reprint.)

Two Cases of Typical Dermatitis Herpetiformis. By Louis A. Duhring, M.D. (Reprint.)

Case of Dermatitis Herpetiformis of the Pustular Variety. By Louis A. Duhring, M.D. (Reprint.)

External Urethrotomy: A Plea for its Early Performance in Minor Traumatism of the Urethra. L. B. Bangs, M.D. (Reprint.)

Bollettino della R. Accademia Medica di Genova. Second year. 1887.

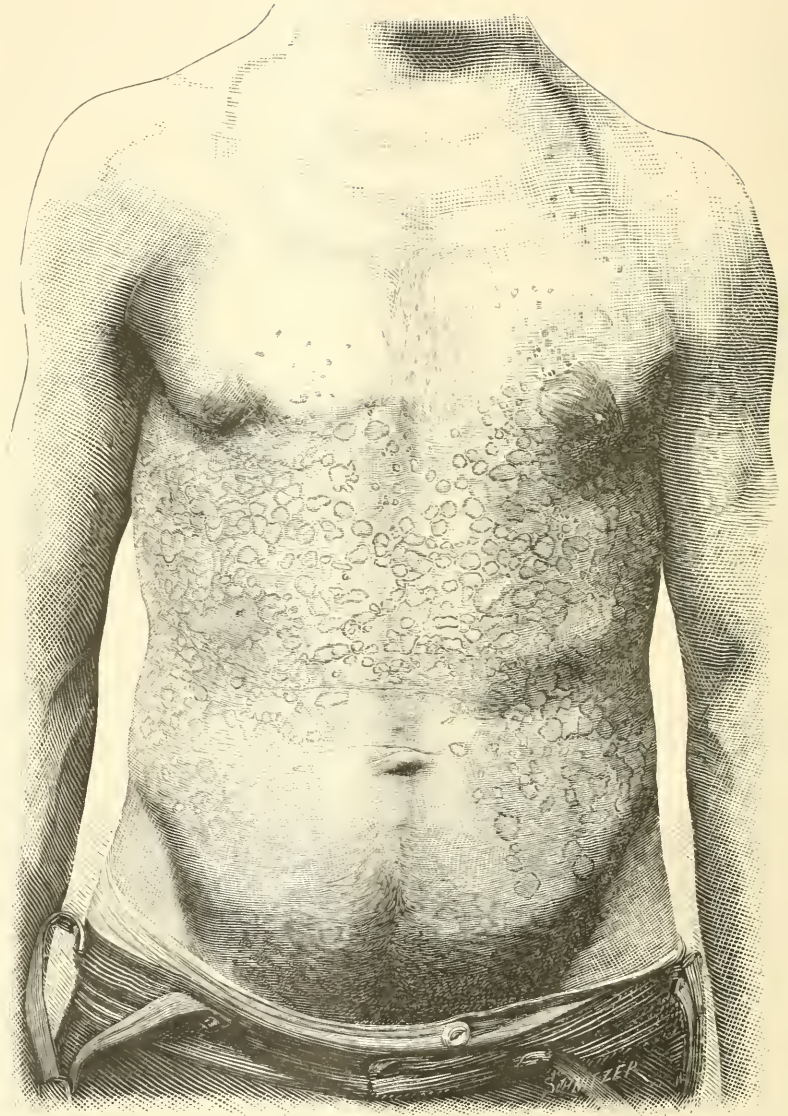
Bericht der Syphilitisch-Dermatologischen Klinik des Professor Lang. Innsbruck. 1886.

Das Sool-bad Kreuznach. Von Dr. Edward Stabel. Reinhard Schmethyl, Kreuznach.—Ger.

The Mineral Waters of Kreuznach. By Edward Stabel, M.D. Asher & Co., London.

Iritis. By A. G. Sinclair, M.D.

Développement de la Méthode de Scarenzio. Par George Smirnoff. Frenckell & Fils., Helsingfors. 1886.



CASE OF PURPURA WITH CIRCINATE LESIONS.

JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

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VOL. V.

OCTOBER, 1887.

No. 10.

Original Communications.

A CASE OF PURPURA WITH CIRCINATE LESIONS.¹

BY

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Physician to the Philadelphia Dispensary for Skin Diseases, and to the Skin Department of the Philadelphia and Howard Hospitals.

IN the early part of last April there applied at the service of the Philadelphia Dispensary for Skin Diseases a male adult regarding an eruption which had appeared some time previously, and through the persistence of which the man had been finally led to seek advice. The patient was forty-four years of age, strong and robust. On examination the trunk, and, to a slight degree, the upper parts of the arms and thighs, were found to be the seat of a peculiar eruption. The lesions were macular, without elevation, of a reddish purple and bluish color, and the greater number of annular form. Here and there could be seen small pin-head to small pea-sized simple macules; those of larger area were ring-shaped, the central part of a faint bluish or dark tint, and the border, from one to several lines in

¹Read at the 11th annual meeting of the American Dermatological Association, September 1, 1887.

width, of a reddish or a reddish blue color. Upon careful investigation all stages from the plain macule to the perfectly formed ring could be seen. The developed lesions, those about the size of a dime, were most conspicuous, the color being of a purplish blue shade. While many of the advanced lesions were almost perfectly annular, many also were irregularly rounded, and in places several had merged and given rise to larger patches with tortuous margins. The eruption existed in greatest profusion upon the anterior part of the trunk, across and above the epigastric region. There were few spots on the upper part of the arms and thighs. The lesions from beginning to end were of a hemorrhagic nature, there being no preceding or accompanying hyperæmia. According to the statement of the patient, the eruption had first appeared, as small round spots of a reddish or orange-red color, about three months previously just above the umbilicus and then gradually extended. As the spots became the size of a small pea the centre began to disappear, and in this manner the type of the eruption had become circinate. There were no subjective symptoms, and apparently, and so far as the patient himself knew, his general health was good. The case remained under notice about two weeks, at intervals of a day or two, and in this time the course of the lesions was noted to be the same as the man had described. The patient then ceased his visits to the dispensary and was not seen until four months later—the middle of last month (August). An examination disclosed the fact that the eruption had almost disappeared; here and there, over the upper part of the abdomen traces being seen in the form of irregular, serpentine, faint bluish lines or bands. In all the process had lasted eight or nine months.

The literature, so far as a somewhat hasty search shows, records but one case of a similar nature—a case reported by Drs. Duhring and Van Harlingen in the *Medical and Surgical Reporter* of August 3, 1878. In their case the eruption was confined to the legs, and the annular form was not noted until several months after the disease first appeared; in the case just reported, the eruption was practically limited to the trunk, and the lesions from the start tended to become rapidly of the circinate type.

1411 SPRUCE STREET, PHILADELPHIA.

Erythema essentiale.
 Varieties : — E. papulatum.
 — E. iris.
 — E. marginatum.

Neuropathic.
 — Eczema neutriticum.

Impetigo simplex.
 Varieties : — I. per scalpiginum.
 — I. califica.

Impetigo contagiosa.
 Ecthyma cachecticum.
 Ecthyma syphiliticum.

Varicella exanthem.
 Variella exanthem.
 Vaccinia exanthem.

Molluscum contagiosum.
 Epithelioma.
 Varieties : — E. superficiale.
 — E. profundum.

Carcinoma.
 Varieties : — C. molle.
 — C. colloides.
 — C. melanodes.

Kerato-chromatosis.
 Epithis.
 Chloasma caloricum.
 Chloasma e causticis et acerbis.
 Chloasma traumaticum.

Naevus pigmentosus.
 Lentigo.
 Chloasma hepaticum.
 Chloasma uterinum.
 Macule leprose.

Leucoderma e causticis.
 Leucoderma traumaticum.
 Vitiligo.
 Leucoderma neuroticum.

I. ERYTHEMATA SIM.

Per irritationem lo-
calem.
Parasitic.
Symphomatic.

Infections.

Paranthoses.

Hyperchromatoses.

Idiopathic.
Congenital.
Hereditary.
Symphomatic.

Idiopathic.
Dactylopathic.

CHLIZACEOUS AFEC-

VARIOLOUS AFEC-

AMYLOID PARAN-

CANCEROUS AFEC-

PARACANTHOSSES.

HYPERCHROMATOSSES.

ACHROMATOSSES.

Chromatoses
 Epidermidis.

TRIBES. SUB-TRIBES. FAMILIES. GENERA. SPECIES AND VARIETIES.

HYPERDESMOSES.
 — *Per distensionem cutis*.
 — *Macrosomia*.
 — *Lucea atrophica obstrata*.
 — *Infia atrophica testatensis etc.*

[illegible]

THE CLASSIFICATION OF SKIN DISEASES.¹

BY

EDWARD BENNET BRONSON, M.D.

THE study of correlated phenomena, of whatever nature, can never be intelligently pursued without logical arrangement of the subject matter, without some sort of orderly classification. The numberless attempts in this direction with which the study of dermatology has been marked ever since its phenomena have attracted scientific attention testify to the common apprehension of a necessity. But a cursory survey of these attempts reveals a singular incongruity in their points of departure. Limiting our survey to the past hundred years, it will be seen that the principles according to which skin diseases have been classified at various periods, and with more or less consistent purpose, were chiefly based upon the following considerations:

1. The physiognomy of local lesions, supposed to be pathognomonic.
2. The general clinical features and course of the cutaneous affections.
3. The pathological anatomy or form of the pathological process.
4. The relations of the affections to their anatomical and physiological sources.
5. The pathogenesis of the affections as regards their relation to certain general diseases or morbid processes.

Each of these considerations, in turn, has been assumed as the cardinal factor for determining the separation of the various affections of the skin into classes or major groups. It suits my purpose to briefly analyze certain of the classifications thus produced, endeavoring to point out their several defects with a view of proposing in the end a system of my own which, while it shall not sacrifice what is most desirable in the classifications of the past, will hope to evade their chief sources of error.

In 1776 Plenck made an elaborate attempt to apply to diseases of the skin the principles of classification which Linnæus had so successfully employed in botany. Like that of the latter, the classification of Plenck was an artificial one, based as it was upon certain salient features or properties which the individuals comprising each of the general classes had in common

¹ Read before the American Dermatological Association, 11th annual meeting, 1887.

with each other. The ocular appearances constituted chiefly the basis of division and the evident aim of the classification was to facilitate diagnosis. Such were its defects, however, that the result was little else than confusing and in the attainment of its chief object it signally failed. These defects were much less conspicuous in the classification of Willan, which followed some fifteen years later. In the latter the separate divisions were more clearly differentiated from each other. The lesions according to which the classes were denominated bore a more essential relation to the included diseases than in the corresponding divisions of Plenck. They were believed to be in a sense pathognomonic so that it was at once possible to determine to what class any skin disease belonged by ascertaining its elementary or typical lesion. It is easy therefore to account for the popularity that Willan's classification so rapidly acquired and for the sway it still holds over some of the foremost dermatologists of England. Its renown so eclipsed its predecessor that the merit of priority that justly belongs to Plenck has been entirely ignored. Though Willan elaborated the scheme so as to render it more practicable it was essentially the system of Plenck and its inherent defects are qualitatively the same. As in Plenck's divisions the diseases are distinguished solely according to their external appearances. The lesions regarded as typical features of the diseases included under the several orders are only pathological products, accidents merely, not essential properties of the morbid processes which constitute the several diseases, and from them little or nothing can be legitimately inferred with regard to the true nature of the latter. The natural tendency of such an artificial classification is to the grouping together of affections that pathogenetically are wholly unrelated to each other. Moreover, where a disease has a polymorphous character, it is liable to reappear in different groups. But notwithstanding its obvious defects, Willan's classification was the means of giving a decided impetus to the study of diseases of the skin. Directing attention as it did to their characteristic lesions, and thence to the fact that every skin disease has a physiognomy of its own, the observation of these affections was henceforward pursued with a degree of zealous interest never before known, and the name of Willan fairly marks an epoch in the progress of dermatology.

Of the next form of classification, as enumerated above, the chief exponent is Alibert. With the advent of the natural systems of classification in botany and zoölogy, first introduced in the former by Antoine Laurent de Jussieu, elaborated

by Decandolle, and afterwards applied to the animal kingdom by Cuvier, a parallel advance was soon attempted in the classification of diseases. That the first labored efforts in this direction met with but indifferent success showed merely that the progress in the knowledge of morbid phenomena had not kept pace with the studies in the morphology and physiology of the animal and vegetable forms of life. Though the accurate discernment of natural groups in the crude science of dermatology was as yet impossible, these early attempts were, nevertheless, a beginning in the right direction.

Alibert may justly be called the father of the natural system of classification in dermatology. His was the first systematic attempt to classify cutaneous diseases according to their inherent natural affinities. Previous attempts had been made, usually merely for convenience of description rather than with any aim at scientific accuracy, to classify them in accordance with certain general principles, precepts, or preconceived notions, relating to therapeutic indications, to topography, to the acute or chronic, idiopathic or symptomatic, critical or depurative characters of the diseases, but Alibert sought by inductive process to determine what were the forms of morbid action to which the skin was subject, at least, so far as they were evinced clinically, and in accordance with these his groups were arranged. They were figuratively represented as a tree ("*arbre des dermatoses*") in which it may be presumed the trunk stood for cutaneous disease in general, while the boughs, branches, etc., represented genera, species and varieties. The imperfections of Alibert's system are well known, and his classification has long been superseded by others. But, though "the tree" is fallen, its materials supplied no small part of many structures that succeeded it. The influence of Alibert upon the classification of Fuchs, and at later periods those of Rayer and Bazin is very apparent.

The classification of Ludwig August Struve (1829) was, in many respects, a compromise between the classifications of Willan and Alibert, though superior to the former in that it recognized the natural affinities of diseases as the true basis of division rather than the presence merely of predominant lesions, to the latter, in that while Alibert recognized only obvious clinical characters in differentiating his groups, Struve sought to make the distinctions more fundamental by referring them to a physiological basis. Many of his divisions have been adopted with comparatively slight modifications in the classifications of

Hebra and of Auspitz. For practical utility, for simplicity and freedom from the bias of preconceived notions, it far surpassed the elaborate but complicated classification of Fuchs a decennium later.

At this period in the history of dermatology, the necessity for a natural classification was fully appreciated. But the difficulty was then as it always has been, to establish a point of departure. No basis of division had yet been discovered that was really fundamental, or that definitely indicated the inherent nature of the diseases constituting the several groups as they were divided. We have seen how inadequate are the elementary lesions to the expression of natural groups, and it is also unsafe to rely upon mere clinical resemblances. Moreover, where an attempt had been made, as by Fuchs, for example, to form divisions of skin diseases according as they were related to certain general diseases or forms of morbid action of which, however, the former were only incidental effects, the result had not been satisfying. For unless the assumed form of morbid action is the necessary and constant condition of the cutaneous affections it is supposed to cause, it cannot legitimately constitute a fundamental basis of division. In certain divisions of Struve and Rayer, which were physiological in character, a near approach was made to the truth, but where secondary diseases were concerned, recourse was had to the artificial system of Plenck and Willan.

It was doubtless an appreciation of the above defects that first led Erasmus Wilson, in 1842, and Rosenbaum, in 1844, to locate the starting point of cutaneous diseases in the anatomical structure of the skin. Their great difficulty was to fix the anatomical seat of those diseases, chiefly inflammatory, which were dependent on vascular disturbance and involved different structures of the skin. Wilson classed them all with diseases of the corium, while Rosenbaum sought to solve the difficulty by locating all such affections in the sebaceous glands. However crude these efforts, they contain a germ of truth which should not be lost sight of and which it will be my endeavor later to more fully elaborate. The same germ appears in the later classifications of Cazenave and Hebra, in such of their divisions as were anatomico-physiological.

In an anatomico-physiological classification, the basis of division relates to anatomical changes or functional anomalies in the skin itself. While not avowedly etiological, it approaches more nearly than any other the local and immediate cause of

the disease. Its avowed object in most cases has been simply to classify the affections according to their local processes. Such was the last classification of Cazenave, as also was that of Hebra. Between these two classifications there exists a relation very similar to that between the systems of Plenck and Willan. Both Cazenave and Hebra aimed at forming a natural division of skin diseases arranged according to their most essential features as exhibited in the local processes. No account is taken of specific etiological factors in the primary divisions, except in the group designated by Hebra as "*Parasitæ*," and that termed by Cazenave "*Foreign bodies*." For a part of Hebra's classes the pathological anatomy is taken as the basis of division; for others the functional anomalies of the cutaneous blood vessels, nerves and glands. In a sense this classification is in its form strictly dermatological. It relates to no remote or predisposing conditions, it is committed to no hypothesis of pathology or etiology, but simply presents the local conditions as they exist in cutaneous disease. Nevertheless, the method of the system is not wholly an inductive one. There is evident a pre-conception of what morbid conditions should exist in diseases of the skin from analogy with pathology in general and classes are formed to suit such conditions, but the result is not always the production of natural groups of disease. Thus the classes designated *Anæmiæ* and *Hyperæmiæ*, *Atrophici* and *Hypertrophici*, *Ulcerationes*, etc., while their denomination accords with the general scheme, they are not well-differentiated groups. The pathological conditions here designated bear no essential relations to the nature of the affections with which they are associated. They are not constant conditions and are more or less interchangeable with each other. A *hyperæmia* is often inflammatory in character, and readily merges into the condition of exudation. An atrophic condition may be the sequel of an affection beginning with hypertrophy. Ulceration may be incident to simple inflammation, to a neoplasm, or a pseudoplasm.

The general objection, then, to a classification based after the manner of Hebra's, in many of its primary divisions, upon the pathological anatomy is that it is not fundamental. The mere presence of pathological conditions, such as are enumerated by Hebra, does not adequately represent the true nature of the disease; it does not necessarily imply that these conditions may not be due to different processes. These conditions are only properties of the cutaneous diseases, and furnish no clue to the original motives, to the essentially determining factors. They are

effects only of morbid processes, and however constant effects they may be, the same effects may often be produced in many different ways. They are not the most essential factors. The hypertrophy in an engorgement disease is less essential than the process of engorgement; the atrophy in a neurotic disease is less essential than the neurosis; the exudation in an inflammatory disease is less essential than the condition of the blood vessels. The effect of regarding these secondary pathological conditions as prime factors in a classification naturally leads to the association of many incongruous affections. For example, in the class of Hypertrophies appear such ill-sorted affections as chloasma, ichthyosis and scleroderma; but surely these have other affinities much stronger and more important than that which consists in the single element of hypertrophy that unites them here.

There is much to criticise, moreover, in the subdivisions of the classification. By far the most important class, so far as the number of diseases embraced in it is concerned, as well as in the frequency of their occurrence, is the class of inflammations (*exudationes*). These affections are first divided into Acute and Chronic. Of the former there are three groups: I. Polymorphous erythemata. II. Dermatitis. III. Acute vesicular eruptions. Of the Chronic there are five groups: I. Squamous dermatoses. II. Pruriginous dermatoses. III. Acne eruptions. IV. Pustular eruptions and V. Vesicular eruptions. Here the method of division evinces a total lack of co-ordination. In the case of erythemata and dermatitis, it is the general clinical character that forms the basis of division, though the two groups are not clearly differentiated from each other. The generic term, dermatitis, is here arbitrarily made to assume a restricted meaning, implying an inflammation of the skin of common type, but it is not clearly shown wherein it inherently differs from any other form of cutaneous inflammation. Again, in the vesicular, pustular and squamous eruptions, it is the primary efflorescences that constitute the important factors; in the pruriginous dermatoses it is a subjective symptom, while in acne eruptions it is the anatomical seat, the location of the disease. Later classifications which have adopted Hebra's general plan have introduced various modifications in matters of detail which render the more obvious defects less glaring, but inherent objections that pertain to the method of classification cannot be overcome. The great success of Hebra's system was due to an eminently

practical character, derived from the genius of a man uncommonly equipped for his work. It is safe to say that no classification since that of Willan has had so great an influence upon dermatology. So great were its practical advantages that its logical defects were the more easily overlooked.

It remains to examine certain representative systems in which the most prominent consideration in classifying affections of the skin is their dependence upon certain local or systemic conditions of disease, that is, their pathogenesis or in a restricted sense their etiology. Properly an etiological classification would be one in which objects were classified according to their causes whatever the nature of the latter might be. But it is indispensable that these causes have a common basis of comparison lest the result be merely a confusion of ideas. The proper end of any classification is to present clearly to the mind the divergences of the objects classified with respect to some common point of departure; it must exhibit the mutual relations of the separate divisions as well as their differences, their contrasts, but also their concordances.

Between the causes that give rise to diseases of the skin there is great disparity: some of them are exciting, others predisposing, some primary, some secondary, some fundamental, others only modifying, some inherent in the structure affected, some constitutional. To constitute indiscriminately causes so diverse in nature the cardinal factors of division in the same classification can only bring confusion. Nor is the result any more satisfactory when classes of diseases are distinguished from each other according to the presence or absence of certain etiological relations, or what is equivalent when the classification in its primary divisions is partly etiological and partly something else—clinical, topographical, pathological, anatomico-physiological and so on. And yet this has been done repeatedly. Such was one of the great faults of Hebra's system, and Erasmus Wilson's second classification that appeared in 1857 is open to a similar charge. Though its two sections are professedly anatomical, the first comprising "Diseases affecting the general structure of the Skin," and the second, those "affecting the special structure of the skin," the first is virtually etiological, while the second is anatomical. The first section embraces (1) "Diseases arising from general causes," (2) "from special external causes," (3) "from special internal causes," (4) "from syphilitic poison," and (5) "from animal poisons of unknown origin and giving rise to eruptive fevers." The division into two sections according as

the general or special structure of the skin is affected is not only artificial in character, but so far as the first section is concerned it is erroneous, inasmuch as certain of its included affections are as much confined to special structures of the skin as those of the second section. It is difficult to see any conceivable relation between the anatomical division into sections and the general plan of classification in the first section which is purely etiological.

Likewise Bazin divided skin diseases into two grand classes, in the first of which the affections were characterized as "deformities" or "stationary affections," in the second as "affections in the course of evolution." Both classes are subdivided according to their etiological relations. Between the two grand classes it is difficult to discover any natural basis of comparison. The division seems as artificial as were the two sections of Wilson's classification. Even were the diseases of one class always stationary—which they are not—while those of the others represent active processes, the distinction can in no sense be a cardinal one so far as relates to any diversity in the natural affinities of the diseases. Most of the affections embraced in the first class are due to anomalous tendencies of growth, though no such distinction is brought out. In their isolated position there is no possible suggestion of the important relations they bear to the neoplastic and degenerative forms of disease.

In the second class an elaborate attempt is made to express the etiological relations of the groups presented in definite terms of general pathology. Wilson was content in his first section to indicate causes broadly as "general" or "special," "external" or "internal." Bazin not only divided cutaneous affections according as they were of external or internal origin, but further sought to specify precisely what the local or general diseases were to which the skin affections were due. The great difficulty of Bazin's scheme arises from the practical impossibility, with our present knowledge of enumerating all the general diseases that give rise to skin disease. Such an enumeration might not be complete till it included the majority of the ailments to which the body is subject, and ignoring, as it does, the independent characters of the cutaneous processes, we have no guarantee that the cutaneous affections attending all these ailments would always be distinguishable from each other.

As is well known, Bazin attaches great importance to *herpetism* and *arthritis* as etiological factors in cutaneous disease.

These constitutional maladies are regarded not merely as general predisposing causes, but their agency in the production of skin disease is assumed to be as direct, and their cutaneous manifestations as characteristic, as are those of measles or scarlatina or variola, and similarly with regard to other systemic diseases. Of some of these latter this is doubtless true. Of syphilis, for example: all the affections properly denominated syphilodermata are peculiar to, are pathognomonic of, the one constitutional cause; whereas the arthritides and herpetides, far from being pathognomonic, are only occasional and incidental effects of the systemic maladies they represent. Moreover, whatever distinguishing characteristics they may have, they present themselves only as modifications of dermatoses of a common type which may owe their origin to a great variety of different causes. For example, an eczema becomes an arthritide or herpetide only by virtue of peculiarities imparted to it by the constitutional disease. But eczema in all its varieties and phases has a character of its own which justifies its special denomination as an independent form of cutaneous disease, and this independent character it derives not from arthritism, nor from herpetism, nor from any other form of constitutional malady. The classification of Bazin nowhere recognizes this character.

But neither in the case of the herpetides and arthritides, nor in that of the exanthemata and syphilodermata can the constitutional disease be regarded properly as the direct and most essential determining cause of the cutaneous eruption. There must be an intermediate factor. Such an intermediate factor is suggested in Fuchs's classification in the term "apostases," the name given, upon an unfounded hypothesis, it is true, to the class under which the family Arthragoses (which is the equivalent of Bazin's arthritides) is, among others, included. Thereby is implied an intermediate act of metastasis. A similar connecting link is supplied in Auspitz's system by the term "angioneuroses," the name of the class which embraces the exanthemata, the "pseudo-exanthems" of Bazin and also most of his arthritides and herpetides, and implies an intermediate condition of vascular erythism reflected to the skin from the central or systemic disorder. But a classification that takes note of causes only as external or internal, and of the latter only in their relations to special forms of constitutional disease, is little more than a nosological enumeration, in which the most essential relations of skin diseases to each other are lost sight of entirely.

Auspitz's classification is practically an etiological one, though not professedly so. It professes to classify cutaneous affections according to their most essential processes, but in defining the nature of the process the more or less proximate cause of the disease is defined. The cutaneous affections are not referred to specific forms of general disease, but to certain general pathological processes. The pathogenesis is stated in abstract rather than in concrete terms. In its approximation to the truth, it was a distinct advance beyond the circumscribed nosological groups of Bazin, as it was beyond the incongruous and arbitrary divisions of Hebra. Between it and the artificial classifications of Plenck and Willan the long interval had been marked by many stages of progress.

Nevertheless, in certain respects, Auspitz has failed to reach the root of the matter.

In a paper read before the New York Dermatological Society three years ago, I endeavored to point out generally and in detail what appeared to me to be the chief defects of Auspitz's system, and incidentally urged the necessity of a more fundamental classification, at the end presenting an arrangement of the cutaneous diseases, which, though very imperfect, was chiefly intended to illustrate the principles which I had in mind.

The chief objection made to Auspitz's method was that by introducing general or systemic conditions or processes as the exponents of his major classes, he had classified not the diseases of the skin, but certain potential causes of cutaneous disease which were extraneous to the skin itself. It is not that the causes of disease (the etiology) do not furnish a fit basis for classification, but that between different causes the most fundamental, the primarily essential are those which inhere in the skin itself, which appertain to local conditions on which the various perversions of normal cutaneous nutrition and growth must depend. Every classification, whether of normal or abnormal phenomena, should so far as possible be etiological. But it should approach as near as possible to causes which are ultimate. Those causes which are most fundamental, most essential, most pervading, should take precedence and occupy the major places; those that are less essential and more particular, taking lower rank. In the case of bodily diseases the most essential causes inhere in the vital economy and first of all in the peculiarities of structure and function of its separate anatomical divisions.

To Auspitz's plan it is to be objected that the objects classi-

fied are not always in the first instance dermatological. Before an angioneurosis or a neuritis can effect their peculiar interpretations in the skin, before the characteristic cutaneous reaction may manifest itself there must still arise an intermediate factor. There must pre-exist certain special aptitudes, certain susceptibilities that appertain to the affected part, to the anatomy, the structure, the functions, the local economy. So it is in the case of a parasitic disease. The mere presence of a parasite, either on or within the skin, is not absolute evidence of disease. Certain parasites, such as for example, the demodex folliculorum cause no reaction whatever. The reaction must involve the intermediate factor, must put in play agencies that are local and peculiar to the part.

To logically classify diseases of the skin, or of any other more or less independent anatomical division of the body, the first question to be entertained is not what are all the ills that flesh is heir to, but what are the local capabilities of disease—what are the normal conditions capable of perversion? Next, what are the morbid reactions peculiar to the skin, and, finally, to what specific ills is it subject? The capacity of the skin to anomaly, to disorder, to disease, must, first of all, depend upon its own constitution. Were this constitution identical with that of every other organ in the body, then would the diseases be identical, and one general classification would serve for every part. But by virtue of its peculiar anatomical structure and its independent physiological functions cutaneous diseases acquire a special character, and thereby dermatology justifies its existence.

(To be continued.)

SOME OBSERVATIONS UPON THE THERAPY OF LEPR¹.

BY

DR. P. J. UNNA, OF HAMBURG.

MR. PRESIDENT AND GENTLEMEN :

I HAVE accepted the invitation of the President to open a discussion upon the therapy of lepra, and shall attempt to set forth the views which have governed me during the past two years in the treatment of this affection. As lepra is

¹ Introduction of a discussion of the subject before the Am. Dermatological Association, 11th annual meeting.

surely a parasitic affection of the skin, and since more especially the nodes of the skin are composed in greater part of parasitic material, it has been a matter of the greatest interest to me to study the effect of the best of our newer anti-parasitic remedies upon this leproma.

The best means at our command to combat the organisms in the skin, I consider to be those agents which have been named by me reducing remedies: chrysarobin, pyrogallol, resorcin, ichthyol.

According to the theory which I have repeatedly expressed, and, indeed, dwelt upon at some length in my recent article upon ichthyol and resorcin, they are efficacious when employed in a weak form, in that they compete with the organisms for the acid, and in strong applications besides this action they produce an inflammation of the skin which effects an elimination of the organisms. I have had an opportunity to study the action of these remedies for a long period upon five lepra patients, two of whom had acquired the disease in South America, one in North America, one in Egypt and one in the Island of Mauritius. Four presented almost typical lesions of nodular lepra, and one the mixed form, with predominating nerve lesions. All progressed favorably under the influence of the course of treatment, even to the total disappearance of the nodes, and an improvement in the collective symptoms, especially of the general condition of the system. Recurrences are as little to be prevented as in syphilis, after a mercurial cure. Experience has taught that these external methods of treatment must be both energetic and faithfully carried out if constant good results are to be expected. It requires a continuous watchfulness on the part of the physician, and a very willing disposition on the part of the patient. I began treatment with the employment of pure salve made with chrysarobin or one of the other drugs alone. But these drugs could not be employed for a long time in the necessary strength, because of their coincidently injurious effects; chrysarobin affecting the eyes, and pyrogallol and resorcin acting deleteriously upon the blood. For this reason they would have occasionally to be stopped, and the cure thus much prolonged. During the past year, therefore, I have introduced a modification of the method which permits of the treatment being continuously employed for months without interruption.

First of all we may use much smaller doses of reducing agents—as of other drugs used in dermatology—(say about half the

quantity), when we employ an addition of about 2% of salicylic acid to aid in the passage of the drug through the epidermis. By this artifice the injurious by-effects of the drugs are at the same time lessened.

Instead of the formula :

Chrysarobin.....	10
Ointment.....	100

We employed the formula :

Chrysarobin.....	5
Acidi salicylici.....	2
Ointment.....	100

By the use of the salicylic acid the skin begins at once to peel, and there is a predisposition, especially on the flexor surfaces, to wounds and painful surfaces, so that in this case too the course of treatment must be interrupted. To prevent this injurious effect I have added to the ointment as much ichthyol as this active drug will permit. In this mild strength ichthyol has a keratoplastic action and prevents permanent desquamation of the epidermis, and at the same time adds its reducing force to that of the chrysarobin, etc. We have finally the formula :

Chrysarobin.....	
Ichthyol.....	āā 5
Acidi salicylici.....	2
Ointment.....	100

While this is being applied to the trunk, arms and legs, we make use of the following formula for the hands and face, on account of the eyes :

Pyrogallol.....	
Ichthyol.....	āā 5
Acidi salicylici.....	2
Ointment.....	100

We soon discover for ourselves that one patient does better on the chrysarobin and another on pyrogallol, so that we have to make choice of the agent according to the individual.

In making continuous use of these drugs for a long time, especially when an extensive use is made of pyrogallol, it is well to administer internally two grams daily of dilute hydrochloric acid to counteract any deleterious effects of the pyrogallol upon the blood. As a substitute for these stronger ointments for use in children, women and in those of delicate skin, and for application to the genital regions and flexor sur-

faces, we employ the corresponding ointment, made with ichthyol or resorcin as the medicinal agent :

Resorcin	5	Or—	
Ichthyol	5	Ichthyol ...	10
Acidi salicylici	2	Acidi salicylici	2
Ointment	100	Ointment	100

The most mild of all is the compound ointment with chrysarobin, pyrogallol, resorcin or ichthyol made with the addition of the oxide of zinc instead of using simple fat, or we can use equal parts of fat and zinc oxide ointment. Thus :

Chrysarobin.	
Ichthyol	āā 5
Acidi salicylici	2
Ung. zinci oxidi	
Vaseline	āā 50

I would state, in passing, that these *unguenta composita reducentia*, especially the last formula, find universal application in my clinic in psoriasis, herpes tonsurans, favus, and in many dry eczemas of parasitic origin.

From the prolonged use of these salves I observe—

1. A rapid disappearance of those fresh lesions of the skin and hypoderm which are accompanied by rise of temperature and resemble urticaria nodosum. This is important, since from the remains of these nodes, which disappear also spontaneously, though slowly, subsequently indolent lepra nodes are developed.

2. A speedy improvement in the circulation and a disappearance of the swelling of those bluish red portions of skin which are simply enlarged and deformed, and, though filled with bacilli, do not present any circumscribed nodes.

3. A slow diminution in the size of true collections of lepra nodes, especially noticeable in the smaller and younger ones, less noticeable in very old almost encapsulated lepromata.

4. A very noticeable improvement in the general condition of the patient, and especially in the loss of appetite, muscular weakness, nervous depression, irritability, anæmia, etc.

This last effect of the external treatment by reducing agents is found not only in lepra, but also in its use in parasitic infections, in which the skin is not visibly diseased, as, for example, in tuberculosis of the lungs (three cases), and in essential anæmia and chlorosis.

As the influence of this method of treatment upon the oldest standing lepromata of the skin is only one of slow action, these must be treated by themselves in an energetic manner. For

this purpose, as in all cases of circumscribed, obstinate dermatoses we use my plasteryulls, and in these cases the strongest salicylic-creosote plasteryulls, as for example :

1. Acidi Salicylici.....	40.	{ Plasteryulls.
Creosote.....	40.	

Or—

Acidi Salicylici.....	20.	{ Plasteryulls.
Creosote.....	40.	

The lepra nodes are to be surrounded with a ring of zinc paste, then a piece of the plasteryull is laid on, and then the latter and the surrounding ring is painted over again with the warmed zinc paste, and this is in turn dried with a pledget of absorbent cotton. The surroundings of the node are thus preserved from the action of the drug, and the plasteryull can remain *in situ* from two to seven days or more. Underneath it, the epidermis is exfoliated, and the node disappears. In changing the plaster the reddened cutis if found exposed, and the yellow masses of organisms are plainly seen lying within it. If such a patient be placed in a warm bath, these free-lying yellow foci which for the most part are made up of zoogloea, begin to swell and stand out more prominently than the surrounding tissues. After drying, they sink again to their level. As long as the epidermis is still intact, the stronger plasteryull (40-40) may be used. When the cutis lies exposed, the weaker (20-40). The creosote has a double action : first, quieting the pain (for the application of the salicylic acid is quite painful), and in the second place, as an antiseptic agent. Since the plaster sticks quite closely to the skin, the neighboring parts can be treated with the above-mentioned salves. The plasters act very certainly and quickly when their strength is appropriate for the case in hand, but, on the whole, much slower than the same plasters in lupus. The ground for this is a double one. First, the tissues in lupus are softened by the tubercle bacilli, while the skin tissue is very little affected by the lepra bacillus, and there is a tendency to its self-production, and will, therefore, rather be hardened, and not at all softened. In the second place, the lepra bacillus lies separated from the blood vessels in the interior of the lymph spaces, surrounded by a relatively considerable quantity of mucus (zoogloea).

The lymph spaces of the whole tissue are blocked, and filled with infarctions, and hence the interchange of the tissue fluids is delayed and all medicinal action made difficult. Hence

it also comes that parenchymatous injections into the nodes, so long as they are hard and feel stretched to the hand, have a decidedly slight effect. It is only after the nodes have become partly resorbed through the use of salves, plasters, etc., and they have become shrunken from the production of space in the lymphatic system that parenchymatous injections work better. Indeed astringent, contracting injections are more rational than those causing swelling, and thus is probably explained the benefit to be derived from injections of alcohol as recommended by Arning. Upon lepromata of internal organs the combined salve and plaster treatment has only a slight though plainly beneficial effect.

I could establish such an effect in leproma of the nerves of the eye, but especially in a case of a leprous lung and bronchial affection. The weak side of this treatment lies always here and we must, therefore, supplement it, the more it concerns the internal organs. Here naturally internal remedies occupy the front rank, and so soon as I can satisfy myself of the decided efficacy of the reduction agents when used externally alone, I will thenceforth seek to combine this treatment with the systematic internal use of chaulmoogra oil, strychnine, salicylate of soda and ichthyol.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

The Treatment of Syphilis by the Sub-Cutaneous Injection of Insoluble Mercurial Preparations.—The State of the Question in France.

PART FIRST: VIEWS FAVORABLE TO THE METHOD.

I HAVE already given in a previous communication the early researches of Dr. Balzer and Dr. E. Besnier in France upon the sub-cutaneous injections of insoluble mercurial preparations as a treatment for syphilis. This method, which has been experimentally tried for many years in Italy following the investigations of Srenazio, adopted in Sweden, in Russia, and in Germany *à la suite* of the modifications introduced by Smirnoff, met with an almost complete incredulity in our own country, and it is only recently that it has become at all acclimated. We cannot too highly praise Dr. Balzer for having seriously undertaken the study of the subject and for having rendered the method more practical, and especially for bringing out a discussion of the subject in the medical society of the hospitals of Paris which resulted in making the true worth of this new process of mercurialization better known.

Dr. Balzer (*Soc. Méd. des Hôpitaux de Paris*, March 11, 1887) employs as an excipient the oil of vaseline. The following is the formula: Calomel gram., 1.50, oil of vaseline gram., 15, giving about ten centigrams of calomel to the Pravaz syringe (one cubic centimeter). The calomel should be perfectly pure, thoroughly pulverized, washed with boiling alcohol and dried.

It is preferable to prepare the liquid freshly for each series of injections at the very moment of using, thus securing a more perfect suspension and a purer preparation, and the calomel has less tendency to agglomerate in masses. The yellow oxide of mercury employed in the same way by suspension in the oil of vaseline has given results equally satisfactory in Dr. Balzer's hands.

The precautions taken by this author in making the injections are about the same as those recommended by Dr. Besnier which I have already communicated to you. Before introducing the needle he assures himself of the permeability and dryness of the canula, so that if a vessel is punctured in its introduction the blood will flow out readily and thus give warning of this complication. He makes the puncture in the buttocks, at the point where the vertical depression is found, about three or four centimeters behind the great trochanter. He pushes the canula vertically in without any previous raising up of a fold of the skin. He does not practice massage after the injection. He recommends holding the finger for an instant upon the point to prevent any of the liquid escaping, or better still to gently press the skin against the canula as it is being withdrawn and to continue this pressure for a moment after it is wholly withdrawn. This slight manœuvre has for its aim to prevent any of the liquid from finding its way into the intradermic track of the needle, which penetration of the liquid would be a cause of abscess formation. Dr. E. Besnier in his communication of the 25th of March to the *Société Médicale des Hôpitaux*, further recommends the thorough washing of the part previous to the injection with salicylated or carbolyzed cotton wet with a mixture of equal parts of alcohol and Van Swieten's liquid. He further favors compression over the needle wound with a pledget of antiseptic cotton wet with the same solution. He then covers the part with turns of a Vigo plaster bandage softened with heat. Dr. Besnier prefers to inject the liquid deeply into the muscular tissue, believing this practice preferable to that which consists of injecting it into the hypodermic tissues. Above all the parts to be avoided in making the puncture, if severe pains and the formation of abscesses are to be avoided, are the deeper layers of the corium and periosteal surfaces. In taking all the precautions I have enumerated the pains are reduced almost to a minimum. Dr. Balzer says that in the first few days after the injection there is produced at the point of the injection an inflammatory swelling, more or less extended and painful, which varies from the size of a nut to that of a hen's egg. It progressively diminishes during the next eight to fifteen days. At the end of this lapse of time another injection may be made in the neighborhood of the former. During the time of his first experiences with the method Dr. Balzer caused his patients to rest in bed, but now allows them to get up at once, to walk about and to carry on their usual occupations.

At times, however, the local reaction becomes severe, the redness increases, the skin softens in the center of the node, and fluctuation is made out. Having arrived at this stage the purulent collection may be reabsorbed in some instances. More often, however, it finds an exit through the tract

of the canula (canicular abscess) or by a slight punctiform ulceration. These abscesses appear to be aseptic. Kopp and Chotzeu have not been able to find microbes which could be cultivated. Adenitis and lymphangitis are never produced. The cicatrices left are insignificant and often invisible. Pains, though always present, according to Balzer, are almost null; the patients do not keep in bed. The contents of the abscesses are composed of pus of a chocolate color, mixed with considerable blood, red blood corpuscles in equal numbers with leucocytes, fatty matter, crystals of fatty acids and crystals of calomel not yet transformed.

The most frequent causes of this complication are, according to this observer, an insufficient use of antiseptic precautions, a poorly made preparation of the substances injected, possibly alcoholism, but more especially adiposity more or less considerable in the hypodermi, especially in women, for strange to relate abscesses are almost never produced in men.—(Besnier, Du Castel.) Dr. Balzer has published two series of statistics. In the first, out of fifty-one women treated, seven underwent four injections of forty centigrams each, ten three injections and the remainder one or two injections, making a total of one hundred and seven injections from which fifteen abscesses resulted.

In the second series out of eighty injections of calomel there were only three abscesses, and from twelve injections of the yellow oxide there were no abscesses at all.

In his communication of the 11th of March, 1887, Dr. Balzer does not hesitate to declare that he has considered this complication to be without any importance. For him it has no other inconvenience than to cause a loss of a certain proportion of the calomel injected. They would not cause him to renounce injections of calomel in either hospital or private practice.

In a second communication made the 22d of April to the same society upon the lesions found at the point of injection of calomel in a syphilitic subject who died of pulmonary tuberculosis in his service, Dr. Balzer gave the following details:

The transformation of the mercurial powder was accompanied by the production of a partial necrosis of the cellulo-adipose tissue. These necroses are without doubt produced by the intensity of the chemical reaction. Nevertheless, during the life of the patient all the objective phenomena observed seemed to indicate that the resorption of the deposits of calomel took place slowly, regularly and in a normal manner. We are, therefore, forced to ask if in all the other cases similar phenomena were not produced in varying degrees of intensity. Dr. Balzer cannot believe in the constancy of these lesions. In the case mentioned he thinks that the injections had not been made sufficiently deep.

The general condition of the patient was very bad, and it is possible that these two causes intervened to occasion the necrosis observed at the autopsy. Finally he remarks that in certain cases, even in women, injections of calomel are not followed by any apparent local phenomena, which would certainly not be the case if there were always produced small foci of necrosis. We must admit, however, that this observation throws a certain element of doubt upon the subject and we must believe, with Dr. Balzer, that there exist two series of unfortunate cases. 1st. Those in which necrosis is produced, resulting in the formation of abscess, which cases have already been

mentioned by Neisser ; and 2d. Those in which the foci of necrosis appear to become encysted, then cheesy, and then to be gradually reabsorbed.

Dr. Balzer has rarely observed mercurial stomatitis and thinks that this complication may be placed to one side. It appears only to be produced when the dates of injection are too close to each other. He recommends repeating them only every fifteen days or three weeks. The curative effects of hypodermic injections of calomel and of the yellow oxide of mercury are, in his opinion, certainly marvelous. In some cases a single injection suffices to cause a disappearance of the eruptive lesions, but more often two are required. He recognizes the fact, however, that it is at times necessary to inject as much as fifty-five or sixty centigrams of calomel to cause a cure. There are, moreover, rebellious cases which do not give way to this plan of treatment.

The method constitutes, according to him, the best procedure known at the present day for the treatment of secondary syphilis. He advises it even for the tertiary accidents. This method, says he, is the most simple, the most sure and the most precise. It is especially convenient for the treatment of patients in civil and military hospitals, who are thus rendered powerless to prevent mercurialization. It is a cheap method, and if desirable does not necessitate hospital care. Syphilitics submit very well to the injections and return for them at the date fixed by the physician. He has not known of desertions from his wards in the Lourcine Hospital. He believes that the efficacy of this method is due in great part to the long duration of the elimination of mercury thus introduced into the economy. Mercury can be, indeed, found in the saliva and in the urine at the end of a year or more. Further, the rarity of recurrences after these injections show, according to his views, that the mercury thus found proceeds from the mercury injected and not from the exterior, as might be thought from the experiments carried out upon patients indirectly mercurialized by their simple sojourn in the wards of the hospitals.

Dr. Balzer has never seen the patients treated by this method return to the hospital on account of syphilitic manifestations, while the women (only women are received at the Lourcine Hospital) treated by the mouth frequently returned for the treatment of new outbreaks. He therefore considers recurrences the exception in subjects who have been treated by hypodermic injections of calomel. He has been enabled to prove by autopsies, or by the examination of pus from abscesses, that from three weeks to a month only are required for the complete absorption of the mercury injected. This period being passed, no further trace of the calomel is found at the point of injection.

Dr. Du Castel is somewhat less enthusiastic than Dr. Balzer over the new method (*Communication to the Society of the Paris Hospitals*, March 11, 1887). He even inquires if the sudden introduction into the economy of a quantity of mercury relatively large and capable of rapid absorption is always free from danger. For his part, he had observed a year ago in a patient suffering from a severe attack of syphilis an eruption in the mouth after an injection of the yellow oxide of mercury, which was much more abundant than any the patient had previously had. Before the discovery of the oil of vaseline as an excipient he had given up entirely the hypodermic use of insoluble preparations of mercury, because they were too painful and caused inflammatory reaction of too violent a nature. He acknowledges

that with the oil of vaseline these accidents are much lessened, and that the injections by its means have become possible.

He has experimentally tried the use of calomel and the yellow oxide of mercury side by side in the same patient. For this purpose he injects the same day in two symmetrical portions of the patient's body (buttocks or lumbar region) equal volumes of calomel for the one side and yellow oxide for the other. He has thus constantly seen the yellow oxide cause less pain and less inflammatory reaction than the calomel. As he considers the curative effects of the two substances equal, he prefers to employ the yellow oxide of mercury. In a patient of his service who died about a month after the last injection had been made, he was unable to find, at the point of injection, either alteration of tissue or residue of the medicinal substance. It is true that the dose injected each time had been only five centigrams.

Dr. Guelpra (*Bulletin Gén. de Thérap.*, April 15, 1887, p. 289), who has observed in the service of Dr. Dujardin Beaumetz five syphilitics treated by the method which now engages our attention, is himself also a partisan quite as enthusiastic as convinced of its efficacy. Such, then, are the works favorable to the method which have been published in France. Let us hasten to correct an error that many physicians and many patients too have committed in reading these communications. Dr. Balzer has never had the intention to claim that he radically cured syphilis so that it would never return, with four or five injections of ten centigrams of calomel, and I am happy to defend him here against those who can attribute to him such an opinion. He has long maintained that four or five injections of ten centigrams each of calomel sufficed in ordinary cases to overcome for a long period the morbid manifestations of secondary syphilis. Thus in closing his communication he adds:

"Far from overturning the rules already established, the methods of Scarenzio and of Smirnoff facilitate their application and make them precise, the method accords marvelously with successive treatment as has been formulated by our excellent Master, Professor Fournier." Dr. Balzer admits, therefore, the necessity of ultimately making injections of calomel at periods which he has not yet determined, in order to cause as complete a neutralization as possible of the syphilitic virus. He does not then make the ridiculous pretention of radically curing his patients by the first series of four or five injections. In how short a time then should new injections be made? Would it be better to make them often? Should the rules adopted by the partisans of Fournier's school be followed in these cases which call for a continuous mercurialization during the first year of syphilis? Or must we, following Diday of Lyon, only institute means of cure when the patient shows new lesions? I am aware that it is anti-medical and anti-clinical to lay down rules of an absolute precision. That we must, first and foremost, take into account the particular case which we are treating. But then there are questions of great importance with which every syphilographer should occupy himself and resolve for himself. For the just appreciation of the method a precise answer is required. We shall see, unfortunately, in presenting the objections already formulated against the hypodermic injections of calomel and the yellow oxide of mercury that the necessity for quite frequent repetitions of the injections seems necessary, if we desire at least to employ them to the exclusion of all other means.

L. BROCCQ.

PARIS.

Selections.

DERMATOLOGY AND SYPHILOGRAPHY AT THE NINTH INTERNATIONAL MEDICAL CONGRESS.

DR. A. R. ROBINSON, of New York, President of the Section, welcomed the foreign guests in an opening address and then briefly reviewed the work done in America in the field of dermatology. He deplored the inadequacy of the facilities for acquiring a knowledge of the subject in our medical schools, and hoped the future would be more encouraging and that better work would be done.

THE RELATIONS OF DERMATOLOGY TO GENERAL MEDICINE

was the title of a general address delivered by DR. P. G. UNNA, of Hamburg, Germany, in which he said that dermatology, as a special branch of medicine, was still young, but deserving of the most careful study.

External agencies occupy a prominent place in the production of skin diseases, and among them parasites are probably the most important.

Properly studied dermatology will advance all other branches of medicine. Experiments upon the human skin has already led to the knowledge of new facts. Could a central, well-endowed institute be established where scientists might work together, dermatology would quickly become one of the most important specialties and contribute largely to the progress in all branches of medicine.

DR. P. G. UNNA, of Hamburg, Germany, read a paper on

SEBORRHOEIC ECZEMA

which will appear in full in a later number of this JOURNAL. An oil painting of an illustrative case was shown, together with microscopical preparations.

DR. ROHÉ said that as similar microscopic work had not been done by others in this disease, we were not in a position to question Dr. Unna's claims.

DR. ZEISLER said we could but admire the closeness of Dr. Unna's observations and his descriptive powers, which must have brought to the minds of all cases which they had themselves observed. In this country we call such cases as those described seborrhœa, and he had considered them due to hypertrophy of the sebaceous gland endothelium.

DR. ROBINSON, the President, said much difficulty was experienced in classifying eczemas, because of the great variety of their causes and modifications. He had repeatedly observed eczema and seborrhœa as co-existing diseases and can readily understand their going hand in hand.

DR. UNNA said he was now engaged in a series of experiments with a variety of cultures of micro-organisms found in seborrhœa, believing that the irritation produced at the point of fatty deposit was caused by a parasite.

VACCINATION DURING THE PERIOD OF INCUBATION OF VARIOLA.

DR. WILLIAM WELCH, of Philadelphia, read a paper with the above title in which he claimed that it was not irrational to suppose that the changes which are taking place in the system before the appearance of symptoms

may be arrested. In this stage he has found that vaccination in fact does modify the disease, and in many instances, he believes, has wholly prevented the attack when performed sufficiently early. To secure good results the vaccination must be performed before the seventh day preceding the eruption, and should not be long delayed after the exposure. He reports 144 cases in which primary vaccinations were done at varying intervals after exposure. In 28 perfect protection appears to have been afforded, in 11 the symptoms were very slight, in 19 the protection was well marked, in 20 it was only partial, and in 66 no protection was procured. Ninety were vaccinated early and only fifteen per cent. died, while of the 54 vaccinated between the second and seventh days before the eruption there was a mortality of forty-two per cent.

DR. KNIGHT and DR. LATHROP supported the reader while DR. YEAMANS held different views, believing that many conditions which might affect the case are overlooked.

DR. WELCH acknowledged that he could not bring proof positive to show that those who escaped variola after the vaccination would not have remained free without its protection. Exposure to small-pox, however, almost without exception, results in the disease unless the system is protected by a former attack or by vaccination.

DR. JOHN V. SHOEMAKER, of Philadelphia, read the next paper on

RECTAL ALIMENTATION AND MEDICATION IN DISEASES OF THE SKIN.

The author referred to the absorbent powers of the mucous membrane of the rectum and praised this means of alimentation and medication where the usual method was not applicable. Enemata were required after operations for lupus and epithelioma of the mouth, so as to give the parts rest. In pemphigus, eczema, and other infantile diseases due to or accompanied by alimentary disturbances nutrient enemata and medicines may be thus given.

Cod-liver oil when it cannot be taken by the mouth may be given per rectum in scrofuloderma, etc.

Quinine suppositories are recommended in urticaria and erythema nodosum. Mercury by the rectum effects a cure when other methods fail or are not tolerated by the patient. Arsenic and antimony thus administered are productive of great benefit in obstinate psoriasis when the same drugs given by the mouth have failed.

Opium and belladonna, and opium and quinine suppositories are highly praised in pruritus ani. In giving mercury in this way small doses must first be tried and the quantity gradually increased.

DR. H. KLOTZ, of New York, then read a paper

ON THE OCCURRENCE OF ULCERS RESULTING FROM SPONTANEOUS GANGRENE OF THE SKIN DURING THE LATER STAGES OF SYPHILIS AND THEIR RELATION TO SYPHILIS.

These cases are distinct in many instances from those the result of broken-down gummata. He attributes them to spontaneous gangrene resulting from arteritis or endarteritis which produces obliteration of the cutaneous capillaries and subsequent death of tissue. The ulcers are round and resemble ulcer of the stomach. He considers the process as resulting from syphilis, though not properly speaking of syphilitic character and finds it not influenced by anti-syphilitic treatment.

The author concludes:

1. Ulcers resembling the so-called gummatous syphilitic ulcer may occasionally result from circumscribed spontaneous gangrene of the skin, without the formation of a previous syphilitic neoplasm.

2. Such ulcers may be distinguished by several peculiarities of formation of floor and shape.

3. They are but little affected, if at all, by anti-syphilitic treatment.

4. Spontaneous gangrene in such cases is probably due to endarteritis obliterans.

In the discussion, DR. UNNA, of Hamburg, said that endarteritis obliterans of the smaller vessels in syphilis is now a well-established fact. It is astonishing that in the primary lesions of syphilis we do not have more sloughing than is generally seen.

DR. B. LOEWENBERG, of Paris, France, read a paper in the Section in Otology on

THE TREATMENT AND THE BACTERIOLOGY OF AURAL FURUNCLES.

From the author's researches he has come to believe that :

1. Boils are caused by an affection from without, that is, through the ducts of the cutaneous follicles.

2. The successive outbreak of furuncles on the same individual takes place by auto-contagion, that is, through transport of the cocci upon the skin.

3. Infection from one person to others is possible, and originates from the same process as in No. 2.

This belief has led him to adopt for boils of the meatus the following treatment :

Three or four times a day he employs instillations of a super-saturated solution of boracic acid (one part of the powder to five of strong alcohol). Cocaine often gives momentary relief.

In cultures made from the pus the micro-organism most frequently found was the staphylococcus albus, which was absent in only one case, then came staphylococcus aureus and sometimes staphylococcus citreus. Only in one case all three staphylococci were found together.

DR. G. H. ROHÉ, of Baltimore, Md., read a paper on

STUDIES IN HIRSUTIES.

Hirsuties is defined as an abnormal and excessive development or an unusual and irregular distribution of hairy growth upon the body.

Darwin regarded the affection as an example of reversion to the primitive type.

Unna believes in an arrest of development, and that the ante-natal type of hair which after birth falls out and is replaced by a stronger and firmer growth has not followed this course in hairy persons examined by him.

Dr. Rohé did not think that either Darwin's theory or that of prevented development would account for all cases.

There are two forms of the affection, the hereditary and the acquired. Heredity is usually in the male line and found in almost all cases of universal hirsuties.

The Burmese hairy family, the dog-faced boy and Krao, are examples of this form.

Long-continued irritation may cause the acquired form, or it may follow neurotic disorders, genital disorders, etc.

DR. UNNA, of Hamburg, regarded the paper as prudent, so far as the pathological portion was concerned. He stated that he upheld his theory, which he had put forth as a more scientific one than others which had up to that time been advanced.

He had not been able to study the skin histologically, which is the only way advances can be made, and he urged those who have an opportunity to make such studies.

The direction of hair development changes after birth, and it would be interesting to secure specimens to examine for these changes in the different layers of the skin.

It is certainly an hereditary disease, but scientifically this is not a sufficient explanation.

DR. GEORGE THIN, of London, stated that careful observation had convinced him that the abnormal development of hair was significant of deficient physiological development, and was a sign of weakness and not of strength, as is popularly supposed. Hairy recruits make bad soldiers. Women with hairy lips are not as a rule fertile.

There is a lack of sexual differentiation. Possibly in removing the hairs from women's faces, we are only taking down nature's flag of warning to the male.

DR. GOTTHIEL, of New York, related a case of excessive hair growth upon the face of a lady of twenty-eight coincident with an abrupt checking of the menses. Only three years later, when the menses reappeared did the case become amenable to treatment.

DR. RAVOGLI, of Cincinnati, Ohio, directed attention to the fact that fewer cases of hirsuties began in early life while the calcareous salts of the blood are needed for the proper ossification of the skeleton. After puberty, when these salts are not so much needed by the bones, they are appropriated by the hairy growth.

About the age of forty-five many men have marked increase in the development of hair about the ears and nostrils.

DR. VALENTINE KNAGGS, of London, England, read upon

A NEW METHOD OF TREATING DISEASES OF THE SKIN LOCALLY.

He proposed to substitute for ointments and fixed dressings such emulsions as would be indicated by the following formula :

℞ Paraffine molle..... $\frac{3}{4}$ j.
 Pulv. gum acac.....gr. 160
 Boracic acid... ..gr. 16
 Aquæ ferv.....ad $\frac{3}{4}$ ij.

Stir until emulsified.

Bismuth, zinc, sulphur, or other medicament may be added as desired.

DR. UNNA, and others, while admitting the value of the formula and the method, could not concede that it differed from those in common use.

DR. REYNOLDS read a paper upon the

TREATMENT OF VEGETABLE PARASITIC DISEASES

with an electric current applied to the scalp or other diseased portion of the body in such a way as to favor the absorption or deep penetration of the anti-parasitic solution employed. He claims excellent results for the method in a few cases of ringworm and favus of the scalp.

It is known that solutions of cocaine thus applied to the scalp produce anæsthesia of the entire thickness of the skin.

It is a long recognized law in electro-physics that fluids in a galvanic current move from the positive to the negative pole; and it has been demon-

strated years ago that the absorption of medicinal substances may be induced by applying this principle. Dr. Reynolds first thought of applying parasitocides in this way to the scalp while experimenting with an anæsthesia produced by this method. He thinks, however, that the electricity itself may have a certain influence in effecting a cure.

He employs a battery having a large number of small cells to secure more electrolytic action than would be produced by the same area of large cells. From five to ten cells are usually employed.

The surface to be treated after being cleansed is moistened with the solution, and the sponge of the positive electrode is saturated with the same and applied to the diseased part while the negative sponge is applied moist to some other region of the body.

Two cases of ringworm of the scalp, one having lasted two and a half years and the other for four years, were thus treated and cured in about three weeks. One case of favus is reported cured in about nineteen days—the application being made daily.

DR. THIN said that mercuric bichloride was undoubtedly the most effective remedy in tinea tonsurans. It must be used with caution, however, as a strong solution may destroy the hair papillae as well as the parasite and produce permanent alopecia, and in at least one case death has resulted from its absorption and toxic action upon the system.

DR. ROHÉ thought perhaps the difference in results here and abroad were due to the differences in application. He thought the bichloride, in solution of 1 to 1,000, sufficient if applied often enough, before the new spores had an opportunity to be produced. Fully developed organisms resist much less than the spores. So long as one spore remains undestroyed, so long will the danger last.

DR. YEAMANS regarded the epilatory forceps as the safest and most effectual agent in both diseases.

The whole matter turns upon whether or not we can reach the spores. He believed that it was unnecessary for any case of favus to exist under proper scientific treatment for over four weeks, epilation being practiced daily.

DR. A. RAVOGLI, of Cincinnati, O., read a paper on

LUPUS ERYTHEMATOSUS.

Kaposi had regarded the condition as a neoplasm. Hebra first described it as a seborrhœa, but modified the term by adding to it *congestiva*. All authors mention erythema and congestion as important features of the condition. Sections of the affected area in the primary stage of the disease show dilatation of the blood vessels and hypertrophy of the papillæ in the corium, accompanied by round-cell proliferation, especially marked around the capillaries and sebaceous glands. As the disease progresses the increasing pressure of the migrated cells, by obliterating the lumen of the blood vessel, deprives the tissues of nutrition and produces more or less cutaneous atrophy. There is an increase in the number of connective tissue corpuscles.

DR. RAVOGLI describes colonies of micrococci in the superficial round cells, and believes them to be the inciting cause of the disease through the irritation which they produce upon the terminals of the cutaneous nerves, and thinks the disease should be classed among the infectious diseases. As regards the treatment, the application of mercurial plaster has been considered the best, which the author thinks strengthens the microbe theory. He

has obtained complete cures in three cases by the use of ichthyol, which he thought acted by the abstraction of oxygen upon which the life of the cocci depended.

DR. UNNA regarded as the most important part of the paper that relating to micro-organisms, and he considered it the weak point as well. The cocci must be seen in all parts of the thickness of the skin, and, he believed, in the sweat glands too. He thought micro-organisms probably existed in the disease and would some day be discovered, but could not regard the specimens presented as showing them, and hoped Dr. Ravogli would continue his investigations and make cultures.

DR. THIN said that what were seen under the microscope might be micro-organisms, and might be other bodies. More characteristic stainings would be necessary and sections carried into the deeper parts, showing the same bodies, before they could be regarded as micro-organisms. Furthermore, cultures and inoculations would be necessary to prove the case.

DR. KLOTZ, of New York, thought the discovery of micro-organisms would bring lupus erythematosus into closer relationship with lupus vulgaris, from which it had been too far alienated.

DR. ZEISLER, of Chicago, thought the micro-organism theory a very plausible one. He did not regard the studies in this direction as entirely new, as Morrison, of Baltimore, had made similar investigations. Lupus erythematosus of the mucous membrane is an extremely rare condition. He had observed it in a case in which the mucous membrane of the mouth was affected. It presented a whitish condition of the membrane, the tissues were hardened, and it proved very obstinate under treatment. Caustic nitrate of silver was alone found to influence the condition. He agreed with Dr. Unna as to the value of resorcin and that ichthyol was of little benefit.

DR. ROBINSON, the President, agreed with the others that a micro-organism probably existed, but did not think that Dr. Ravogli had succeeded in demonstrating them.

DR. OHMANN-DUMESNIL, of St. Louis, Mo., read a paper upon

ERYTHEMATOUS LUPUS OF THE HANDS.

Few cases of lupus thus rarely located have been described with accuracy. He had collected forty-five cases as a basis for his paper, which was illustrated with photographs and microscopic sections of the skin, which revealed entire absence of the stratum lucidum, and complete disintegration of the stratum granulosum, but no evidences of the existence of micrococci were discovered. The sebaceous glands were distorted and swollen, and their cavities filled with round cells.

He believes the disease to be essentially an inflammation of the epidermic tissues and the structures developed from them, and the hair follicles and sweat glands usually the earliest seat of the disease. The sebaceous glands are also involved; but the theory that the disease originates in them is disproved by the fact that in five cases observed by the author the morbid process began in the palms, in which situation sebaceous glands are absent.

DR. JOSEF ZEISLER, of Chicago, Ill., next read a

CONTRIBUTION TO THE KNOWLEDGE OF IMPETIGO HERPETIFORMIS (HEBRA).

After briefly reviewing the literature of this rather rare disease, the author referred especially to the work of Duhring. In his opinion it was going too far to include this with other more trivial eruptions under the designation of dermatitis herpetiformis. He regarded the disease as one of an

essentially pyæmic nature, occurring almost exclusively in women, closely connected with the purpereum, and usually ending fatally.

DR. ZEISLER related the history of a typical case from his own practice, illustrated with photographs of the different stages.

DR. UNNA described a case from his practice, which, while resembling both impetigo herpetiformis and dermatitis herpetiformis, he could not regard as either. Iodine in large doses was, however, the only treatment at all beneficial.

To establish the diagnosis, the blebs must contain pus from the very first.

SYPHILIS AND INSANITY.

DR. SAVAGE, of London, said it was the common experience of observers that severe cases of brain syphilis follow secondary syphilis, which has appeared slight. Few idiots appear to have congenital syphilis. Syphilis may cause epilepsy in children who subsequently become idiotic. He did not think there was, properly speaking, a syphilitic insanity.

DR. GODDING, of Washington, said he had never seen mental symptoms which permitted a diagnosis of syphilitic insanity.

DR. SAVAGE said that possibly some acute cases of insanity follow the delirium occasionally seen, or succeed the more severe secondary symptoms such as optic neuritis, etc., or appear with the onset of local paralysis, neuralgias and sleeplessness. Acting as a moral cause syphilis may produce hypochondriasis.

He had observed epilepsy in cases with syphilitic history. Progressive weak-mindedness may follow constitutional syphilis; syphilitic cachexia may cause melancholic symptoms.

DR. A. R. ROBINSON, of New York, read a paper upon

A UNIQUE CASE OF PROGRESSIVE MELANOSIS OF THE SKIN,

the peculiarity of which consisted in the progressive nature of the affection, its long duration, and the situation of the pigment. The patient was a female who, twenty-one years ago, at the age of eight, first noticed a small, dark spot upon the side of the temple. There were no subjective symptoms of pain or tingling in the part. Dark spots the size of a pin point gradually appeared until a patch was formed which covered the whole lateral surface of the forehead. Dark brown pigment granules were found in the rete mucosum, though the spots had clinically a bluish tinge.

DR. A. H. OHMANN-DUMESNIL, of St. Louis, Mo., read a paper on

DOUBLE COMEDO.

Since making a previous communication on this subject, which was published in this JOURNAL, Dr. Dumesnil has continued his investigations and has made a pathological study of the condition which appears to be quite a common one, occurring in $2\frac{1}{4}\%$ of all male hospital patients observed. The process of formation, the author believes, is by the fusion of two contiguous comedones; the intervening septum becoming absorbed.

DR. UNNA did not think that the condition was ever found in those with healthy skin, and had almost constantly discovered scar tissue at the point occupied by the double comedo, indicating previous inflammatory change.

TREATMENT OF SYPHILIS BY INJECTION OF INSOLUBLE MERCURIC SALTS.

This was the subject of a paper by DR. H. WATRASZEWSKI, of Warsaw, Poland, who, after considerable experience had come to give the preference to the yellow oxide of mercury. The injections are given about once a week,

four to five only being found requisite for a disappearance of the symptoms present. Abscesses were not produced. He has found a greater amount of irritation follow the use of calomel.

The formula he usually employs is :

R. Hydrargyri oxyd. flav.....	1.00 gram.
Gummi arab.....	0.25 centigram.
Aquæ destillat.....	30.00 grams.

M. S.—Shake and inject.

Of which a Præz syringe-ful is to be injected deeply into the tissues once each week.

DR. A. R. ROBINSON, of New York, read a paper on

ALOPECIA AREATA.

The author carefully and exhaustively reviewed the literature of the subject of etiology in alopecia areata and dwelt at some length upon the theories advanced by believers in a neurotic origin upon the one hand and the supporters of the parasitic origin upon the other.

Many clinical features and observations were advanced in support of both theories.

Micro-organisms are pretty constantly present, but attempts at cultivation have failed. The complete and sudden falling of the hair is against the theory of a micro-organism.

Organisms similar to those described are found upon the normal scalp. Cultures when inoculated produce only slight inflammation. If the disease is due to a parasite upon the surface, parasitocides should cure it, while in fact they are not successful in controlling it. The disease is not contagious in the usual sense of the word. It may be that the failure of parasitic remedies is due to the disappearance of the organisms before the clinical aspects of the affection really appear, or very soon after the hair has fallen. He has found parasitocides of more benefit when employed early, and they are the most trustworthy means at our command at the present time. Dr. Robinson has been led to believe that the disease does not depend upon any micro-organism to be found upon the surface of the skin or in a hair-follicle, and has looked for the cause in deeper parts.

Sections of skin taken from a spot of alopecia which had existed for one week showed normal epidermis but signs of inflammation in the corium, round-cell collections in the sub-papillary layer, blood vessels dilated, and small arteries containing fibrinous coagulum. The lymph channels in the corium were enormously dilated and contained also a fibrinous coagulum. The sebaceous and sweat glands were not affected.

There was a mild inflammatory condition of the sub-papillary layer of the corium; The same changes were found in other cases of longer duration: one which had existed for several years and caused almost complete baldness showed atrophy of all the structures except the blood vessel walls. The sudden falling of the hair would be explained by the thickening of the walls and coagula in the vessels supplying the affected area. The inflammatory changes leading to temporary or permanent baldness is a disease of the corium and not of the hair structures. Alopecia areata is not a hair disease at all. The author could not consider the disease a trophoneurosis, and the view that it was a vasomotor disturbance of central origin was not to be en-

tertained, hence he looked for a local cause and finally succeeded in finding micro-organisms like those described by Von Sehlen. They were present in the lymph spaces of the corium and sub-papillary layer—some in the papillæ, and also deep down in the corium. They consisted of cocci in masses, colonies, and lines, and in rows in the lymph spaces. Diplococci were frequently seen. In the case of one week's duration micrococci were very abundant. He regards them as causative and their deep situation as explaining the slight degree of contagiousness, and the failure of parasitocides superficially applied.

A lengthy and interesting discussion was participated in by Drs. Unna, Thin, Ravogli, Knaggs, Zeisler and Reynolds.

MULTIPLE SARCOMA OF THE SKIN.

DR. ROHÉ, of Baltimore, Md., presented a patient with this rare disease, characterized by the development within the skin of multiple sarcomatous tumors. The patient was a man of about thirty years of age. The tumors were of about the size of an English walnut, and were situated upon the regions of the back and shoulders, legs and thighs. He was also suffering from tuberculosis of the lungs, and had slight hemiplegia.

MICROSCOPIC SPECIMENS.

DR. W. XAVIER SUDDUTH presented a series of microscoped slides of rhinoscleroma, mycosis fungoides perniciosus, lympho-derma perniciosus, lymph-angioma tuberosa. Multiple pigmented sarcoma and multiple idiopathic pernicious sarcoma. The differential diagnosis between these closely allied forms of disease was discussed.

THE THERAPEUTICAL VALUE OF THE MORE RECENT ADDITIONS TO THE GENITO-URINARY PHARMACOPŒIA.

II.

IN his second and concluding lecture upon this interesting and highly important subject, Mr. Hurry Fenwick first spoke of the value of *Ulexine*.

This remarkable principle was first isolated by A. W. Gerard who extracted it from the young shoots of the *Ulex Europæus*, the gorse or furze common in many parts of the country. Ulexine, Mr. Fenwick finds, is a very powerful respiratory poison, which, however, very largely excites the urinary secretion for a short time. By means of crucial experiments performed upon frogs it had been demonstrated that for the space of two or three minutes a flow of urine amounting to three drops per minute was increased to four times that quantity by a dose of ulexine, but the effect of the drug is very transient.

As regards the human subject ulexine had been given in doses of one-tenth grain for stricture of the urethra; very successful results had been obtained in several instances, but in other cases where the disease was of long standing severe pain and vomiting with blackening of the tongue and other unpleasant symptoms were induced. Some caution, therefore, is requisite whenever ulexine is given.

Papaw.—The milky juice of the *Carica papaya* possesses very remarkable properties as a digestive agent or solvent of fibrine caseine and has long been employed in South America and elsewhere to soften for cooking pur-

poses or make tender, tough or hard meat. This juice, when carefully dried at low temperature and powdered, is called papaaïne, and one part of this powder is capable of peptonizing no less than a thousand parts of fibrine albumine, or muscular tissue; its value in this respect has long been appreciated in America and Germany, but has made little way in England hitherto. In cases of renal stone, Mr. Fenwick had found it of marvelous power in relieving pain and dislodging the stone itself in a very little time.

Damiana (*Turnera aphrodisiaca*).—The tincture of this drug was about the most powerful excitant of the sexual power he had yet noted, and it was therefore found valuable in a variety of cases. It should, however, not be given in larger quantities than 20 to 30 minims at a time, since overdoses were liable to give rise to opisthonotos, and the symptoms generally resembling those of poisoning by strychnine.

Hydrastis Canadensis.—The *Hydrastis canadensis*, or Golden Seal, a favorite medicine amongst the North American Indians and also used by them as a yellow dye, had been found by Mr. Fenwick of the greatest possible value for the treatment of stricture. It exercises a very powerful action upon the muscular system and is more active as well as more manageable than ergot for affections of the prostate, bladder and urethra. An alcoholic tincture of the drug is the form generally recommended, but in cases of various diseases of the mucous membrane the aqueous extract is employed as an injection. Instant relief is frequently obtained by the aid of this preparation, the dose of which is from 20 to 30 minims.

Naphthol.—This agent, which acted apparently by becoming decomposed and furnishing some form of phenol (carbolic), when in contact with the mucous membrane, had been tried with the result that bacteria in the urine and under the wall of the bladder itself were effectually disposed of. Doses of 2 to 3 grains, repeated as required, were preferable to the larger quantities—15 grains—1 gramme—prescribed on the Continent.

Piché (*Fabiana imbricata*).—With this drug the results were not uniformly satisfactory, having, in those instances in which it had been employed hitherto by the lecturer, been found excellent in cases of renal stone and colic, while in cystitis the effect was not an ameliorative one, in tubercular disease it did no good, and an inflamed bladder got worse rather than better by treatment of piché.

Stigmata Maidis (*Corn Silk*).—For renal colic and other diseases of the kidneys, the fluid extract of corn silk had been found by the lecturer so extremely successful a remedy that it might almost be called a specific for the first named affection. The details of many cases were described at length, one being that of a male patient who had suffered for seventeen years from renal colic; after various other kinds of treatment had been tried without effect, the extract of corn silk effected a complete cure in a very short time. Good results had also been obtained in cases of cystitis, pyelitis, tubercular affections, and diseases of the ureter. Sometimes it so happened that the supply of the extract ran short, when the lecturer had found that much benefit was obtained by the administration of infusions of the maize-cob itself.

Chaulmoogra Oil.—A most favorable report was given of the effects of this oil upon leprous and rheumatic patients when applied topically, and syphilitic chancre had also been successfully treated. Internally, it was

given with good effect in tuberculosis, etc., but the peculiarity of the drug so exhibited was that it must be given with meals or on a full stomach rather than an empty one.

Caroba (Jacaranda tomentosa).—Here a drug specially adapted for the treatment of syphilis seemed to be indicated, so far as he had yet experimented; even cases of the “scaly” kind and of long standing were healed very quickly under its influence. Further systematic trials, however, are needed to make us better acquainted with the real powers of this drug.

PARACELSUS.

PLAQUES OF THE VULVA.

DR. BESNIER presented a patient at one of his recent clinics (*Journal de Médecine*, June, 1887) who had whitish plaques upon several different points of the mucous membrane of the vulva, which cannot be better described than by saying that they were absolutely analogous to those termed psoriasis of the tongue and cheeks, leucoplakia, etc. The analogy is further carried out by the fact that these vulvar plaques can also become transformed into epithelioma.

This condition is occasionally encountered after uterine affections, and is also often seen in diabetics, in which case the prognosis is more favorable, for if the sugar can be caused to disappear from the urine the plaques likewise disappear.

If the glycosuria persist, the affection must be treated locally by alkaline injections carefully made after each act of micturition, and by the application of pomades to protect the intact parts from the contact of the irritating liquids. Such a pomade is the following:

R. Pulv. zinci oxidi.

Pulv. amyli.....āā 25 grams.

Vaseline... .. 40 grams.

BENIGNANT PAPILLOMA OF THE BLADDER.

THREE cases were reported by Koch (*Centralb. für Chirurg.*, No. 20, 1887) as having been operated upon in the Tübinger clinic during the past few years: one in a man aged forty, the second in a woman of thirty-four, and the third in a student aged twenty-one. The tumor had not recurred in the first case two years after operation. In the second, however, there was a return at the end of this time, and the last had remained well up to the date of the report.

Forty-one cases of benign papilloma of the bladder in men have been collected, including the two cases in males here reported. These show that the disease is more frequent between the ages of fifty and seventy, and next in frequency between thirty and fifty. The site of the tumor was in the fundus and posterior wall twelve times, in the triangle involving the openings of the ureters ten times, upon the sides five times, and eight times the upper bladder wall. The first symptom uniformly was bleeding, appearing at urination and not depending upon movement. Often fleshy masses were passed with the urine. Another constant symptom was pain and difficulty in urination, with sudden stoppage of the stream. The diagnosis is made by catheterization, endoscopy of the bladder, bimanual palpation, but most surely by exploration of the bladder by the median cut. When the diagnosis is beyond doubt, the high stone operation is the only mode of treatment

which offers a guarantee of a radical extirpation. If the diagnosis is not positive the perineal cut is preferable as an explorative measure. Then, according to the developments of the case, the operation may be done through the rectum or the high stone operation performed in addition.

TINEA IMBRICATA.

IN the last chapter of his excellent article on ring-worm, which has gone through several numbers of *The Practitioner* (London), Dr. George Thin gives drawings of the mycelia and conidia found in the scales from a patient of Dr. Manson, to whom we owe our knowledge of this form of ring-worm.

Hitherto, Manson considers that *tinea imbricata* has been confounded with *tinea circinata*. It usually involves a very large surface, such as an entire limb or side of the trunk, or if unchecked, the whole surface of the body. It is characterized by the abundant formation of scales, successive waves of which are imbricated over each other. It excites very little irritation, and contains the fungus in profusion. Manson distinguishes it by the extent of surface involved, the absence of irritation, the imbrication and the profusion of fungus; the amount of fungus in *tinea circinata* being usually not great. He also states that he has succeeded in inoculating this disease and *tinea circinata* on different parts of the same individual, the characteristic differences being maintained. All of Manson's patients had been in the Straits of Malacca or the islands of the Malay Archipelago, and he thinks the disease is the same as that described as *pita* or *Tokelau itch*.

Under the microscope, the same mycelium and spores are found as in *trichophytosis*, but, in addition, mycelia of totally different aspect, some smaller and some larger than those of *trichophyton*.

TINEA TRICOPHYTINA UNGUIUM.

THIN says that although onychomycosis may occur in the nails of both fingers and toes, it is, however, usually present in those of the fingers alone. There is nothing distinctive in the degeneration of the nail substance caused by the fungus, and without the microscope it would be impossible to distinguish the disease from psoriasis. Eczema and lichen ruber when they affect the nails produce similar appearances.

The nail is brittle, opaque, laminated, thickened and soft, particularly at its free border, under which the mass, more or less thick, of softened, broken-down nail substance can be seen.

Examined in a solution of potash this substance shows the presence of *trichophyton*. It is very obstinate. The nail should be scraped very thin, liquor potassæ being applied with a brush to soften it if necessary. Creosote or acetic acid is now applied, or, better still, a solution of the perchloride of mercury (two to five grains to the ounce) applied twice or thrice daily. Treatment must be carefully and persistently carried out.

THE PATHOLOGY OF LICHEN RUBER.

KÜBNER (*Berl. Med. Gesell.*, April 6, 1887) recognizes two varieties of this affection, viz.: *lichen ruber acuminatus* and *lichen ruber planus*. He rejects the opinion of Robinson (New York) that the two diseases are distinct, since patches of acuminate variety are sometimes found in cases

of lichen planus, although he acknowledges that the universal eruption of the former disease is a much more serious affection than that of the latter. Since 1879, Köbner has collected 52 cases, of which 25 were men and 27 women. But few were cases of the acuminate sort, and in only two of these was the disease universal. In the microscopic examination of young papules of the plane variety, Köbner found a perivascular cell infiltration quickly followed by a proliferation of the malpighian layer, with changes in the hair sacs and sweat glands which are secondary and consecutive to these. In old patches of the acuminate form, the cell infiltration is well marked and deep reaching, and is accompanied with an anomaly of the horning process, together with a remarkable hypertrophy of the sebaceous glands and of the remains of the atrophied hair sheaths. He believes that the disease is of nervous origin, and cites two cases of his own, in one of which the disease developed synchronously with a bulbar paralysis, and another in which it developed along the course of certain nerves, and quotes corresponding cases of F. Fox and S. Mackenzie.

The itching, too, may precede the outbreak of papules by many months, or attacks of urticaria may occur for years previously, or may commence only shortly before the lichen appears, showing, as Köbner thinks, the increased excitability of the vaso-motor nerves. Lassar had promulgated the theory that the disease was parasitic, and that the parasite was probably derived from raw leather; but Köbner found that only a quarter of his cases had been in the habit of handling leather, and in only two cases was the leather undressed. Indeed, his patients were derived from all classes, and he had been quite unable so far to discover any common cause for their affection. Nor had he been able, after careful examination, to discover in any of his specimens the bacillus which Lassar had described.

Lassar defended his position and stated that he could still discover the bacillus in his preparations. He objected [very rightly] to Köbner's hypodermic arsenic injections, and preferred to give the drug in pill form, or to use Unna's ointment (hydrarg. perchlor. 0.1%; acid carbolic, 10%), which worked excellently. He had found one thing in common in many of his cases, viz. : that they were brought into contact with animal matter. He had, moreover, noticed the disease among those who had to do with rags, such as fitters, or with dirty money or notes, such as 'bus conductors or cashiers.

[The bacillus is at present simply a suggestion, even if its discovery be confirmed; for we are no longer simple enough to impute specific pathogenic properties to bacilli which may have been found in morbid tissues without the assurance derived from successful inoculation experiments. Lichen ruber acuminatus is almost unknown in England, but lichen planus is by no means uncommon. The majority of my cases are women; they suffer from no nervous affection, are nearly all otherwise well and strong, are generally readily cured, and are not in any special way connected with raw leather, rags, or other known channels of disease.]—H. G. BROOKE, in *The Medical Chronicle*, Manchester, Eng., July, 1887.

DERMATOSES FROM MENTAL EMOTIONS.

PROFESSOR LELOIR (*Annales de Derm. et de Syph.*) says that by determining vaso-motor disturbances, moral shock or emotions may produce skin

eruptions. These are of no great importance when of temporary duration in those not predisposed; they may become of very great moment in those who are.

Anæmia, erythema, urticaria purpura urticans, eczema psoriasis and a number of other diseases have been observed from this cause.

The eruptions appear quickly, are superficially situated, of short duration and unattended with any decided subjective symptoms. Women are the most common subjects, and usually those of a nervous impressionable constitution. As to the treatment, nerve sedatives and externally protective and soothing applications are advised.

BORACIC ACID FOR STERILIZING URINE.

THE two prime dangers in the operation of internal urethrotomy are urethral fever and hemorrhage, presuming, of course, that the operator has assured himself of the soundness of his patient's kidneys before operating. In a recent conversation with an eminent surgeon of one of the New York hospitals, he remarked in response to a statement that I made, that "the millenium in urethral surgery would be reached whenever the means was discovered of sterilizing the urine by internal medication." The ground for this strong statement was the fact that urethral fever, that dread of operators upon the urethra, is due to infiltration of the tissues of the body by a germ-laden urine.

About the only attempt that has, up to quite recently, been made to prevent urethral fever from following urethrotomies and kindred operations, has been the internal exhibition, prior to the operation, of quinine and the subsequent use of antiseptic injections. My remark that called forth this surgeon's statement was to the effect that we can, by the free administration of boracic acid for twenty-four hours before, and for some days subsequent to the operation, render the urine absolutely sterile, and thus, without any quinine whatever, escape all danger of urethral fever. At that time my experience with this agent thus given was hardly sufficient to warrant a positive assertion. Something less than a year ago I ordered, in a case characterized by purulent and fermenting urine, the exhibition of boracic acid in ten-grain doses. The effect for good was so immediate and striking that I determined to use the remedy instead of quinine in my next urethrotomy, having several times previously encountered severe fever in this operation, despite the free exhibition of quinine.

In some forty subsequent urethrotomies, several for strictures of small calibre, a number under adverse circumstances, I have had but one case of urethral fever. In that case, operated upon in the practice of a neighbor physician, last month, for stricture of small calibre in a negro, the attendant, by some misunderstanding, omitted the boracic acid after the first subsequent day. A violent chill, with temperature of 105° rapidly following, occurred on the third day. The bladder and urethra were at once washed out with boric acid, and its internal exhibition in twenty-grain doses renewed. Happily the patient recovered, having served, if but in a negative way, to demonstrate the value of boric acid as an internal antiseptic. I usually employ ten grains in compressed tablets every three hours, though as high as thirty grains every three or four hours may be given without any irritating or otherwise injurious action upon the alimentary canal. I should,

of course, mention that full antiseptic precautions are always employed as regards the instruments used, and that in most cases I also wash out for several days the bladder and urethra with an ordinary hot boric and bichloride solution—an admirable means, by the way, for arrest of hemorrhage, in addition to those already laid down in works on the treatment of stricture. The misgivings with which I formerly performed this wonderfully salutary operation are wholly gone. Hémorrhage, the other danger, is growing more and more rare under improvements in instruments and operative procedure, and when it does occur is ordinarily easy of control. Cocaine, of course, has fully demonstrated its value in penile surgery. The sterilizing bath which I use for my instruments is a saturated solution of hydronapthol. It is much superior for that purpose to carbolic acid.—DR. E. R. PALMER, *American Practitioner and News*.

Book Review.

A PRACTICAL TREATISE ON THE DISEASES OF THE HAIR AND SCALP. By George Thomas Jackson, M.D., Instructor in Dermatology in the New York Polyclinic; Assistant Visiting Physician to the New York Skin and Cancer Hospital; Member of the New York Dermatological Society, etc. New York: E. B. Treat. 1887.

IN the neat little volume of 356 pages the author has given a concise statement of our present knowledge of the diseases of hairs and of the hairy parts of the human body, and has wisely devoted considerable space to the portion which treats of the hygiene and care of the hair. Dr. Jackson has undertaken to supply a want which, from his own experience, he has felt to exist for a scientific special treatise upon this subject. That he has succeeded, a perusal of the book will show.

The work is divided into four parts; the first fifty pages being devoted to a general consideration of the anatomy and physiology of the hair and the hygiene of the hair and scalp.

The physiology of the hair is considered with special reference to the foetal development and embryonal changes in the hair, and those which take place at puberty. Much attention has been paid to the proper care of the scalp, in infancy and childhood, from the very moment of birth. The proper choice and proper use of toilet articles is dwelt upon. The fine tooth comb, false hair, wigs and night-caps are all deprecated.

Part Second treats of the essential diseases of the hair, in which class he includes alopecia areata, believing that the most probable cause of the disease is a trophoneurosis.

Part Third, which is devoted to the parasitic diseases, includes chapters on trichophytosis, favus, pediculosis and Beigel's disease.

Part Fourth deals with those diseases of the hair which are secondary to diseases of the skin.

The work contains a number of illustrations which will aid the student, and the prescriptions frequently met with in the text will be appreciated. The specialist, will gladly welcome the volume as an addition to American

dermatological writing, having its place alongside of such other special monographs as those on Acne, Eczema, Drug Eruptions, etc., which have recently appeared.

A bibliography of twenty-six pages, collected from over six hundred journals, special treatises, and general works bearing on the subject, adds to the value of the volume. C. W. A.

Items.

INSECT BITES.—Bernbeck states in the *Algem. Med. Centr. Zeit.* that salicylic acid one part to nineteen parts of flexile collodion, or one part of corrosive sublimate to a thousand parts of the collodion painted over the "bites" will quiet the pain at once and usually prevent swelling.

TICK BITES.—The various ixodes of our woods often inflict painful and troublesome bites. Dr. A. Crull (*Medical Age*) says they have a particular liking for the penis and prepuce because the skin is here easily penetrated, and the insect fastens its bearded proboscis with great tenacity into the delicate skin. If undisturbed it buries its head beneath the skin, and after it has glutted itself with blood dies and drops off without injecting any poison and no swelling follows. The bite of the smaller is more irritating than that of the larger ticks. If removed with violence the head is apt to be severed from the body and remain in the tissues. He advises cold water and astringent dressing.

FLEAS may be "totally annihilated," according to a writer in the *Madras Mail*, by sprinkling the floor with powdered sweet flag root (*calamus aromaticus*).

PEDICULI PUBIS, according to the *Journ. de Méd. et Chir. prat.*, are destroyed by a five per cent. calomel ointment with less inconvenience than by the more commonly employed blue ointment. A corrosive sublimate bath of about half an ounce to thirty gallons of water, will kill all the pediculi.

Vinegar applied to the hairy parts will best detach the eggs from the hairs and destroy their vitality, without which recurrences may be frequent.

ETHER AS A PARASITICIDE.—Ether has been highly recommended by Dr. Thomas, of Alameda, Cal. (*Reporter*, July 23, 1887.) A single application effectively destroying pediculi pubis.

SALIX NIGRA AS A SEXUAL SEDATIVE.—This drug has been recommended by various writers as a sexual sedative. It has been used with success in spermatorrhœa and nocturnal pollution. Dr. Hutchinson, of Glasgow, writes in the *British Med. Journal*, July 30, 1887, that he has employed the fluid extract in half-drachm doses three times daily with benefit in such cases, and in the more numerous class of cases in which he has used it, viz.: women who suffer from pain in the ovaries and nervous irritability reaching its height at the menstrual period.

PINUS CANADENSIS, of the colorless variety, is recommended by Dr. White, of Philadelphia, as a soothing application for both slight and severe burns.

BISMUTH SUBIODIDE has been used by Dr. Chassaignac (*New Orleans Med. and Surg. Journal*, July, 1877) as a dressing for wounds, ulcers, chancres, chancreoids, etc., with results confirming the good opinion held of the drug by Reynolds and others who have employed it as a substitute of iodoform.

BLISTERS IN CHILDREN should be used with the greatest caution, according to Dr. Comby (*Le Progrès Médical*, May 21, 1887). The traditional employment of blisters in certain diseases of childhood, such as scrofulous affections of the skin and mucous membranes, king's evil and the like, often brings about a suppurating wound which is a drain upon the child's system, and occasions just the eczematous and impetiginous eruptions which it has been intended to prevent or cure. The author reports a case which came under his observation, of a child, two years of age, who had been treated for a double broncho-pneumonia by the application of two large blisters, one kept on for six hours and the other for four. Large suppurating and gangrenous sores resulted, and the child soon died. In the author's opinion death was hastened by the blisters.

ENDOCARDITIS and gonorrhœa endocarditis, bearing a causal relation to gonorrhœa, is one of the rarer complications of the disease, and is usually associated with gonorrhœal rheumatism. Dr. Von den Velden (*Centralblatt f. d. Med. Wissensch.*, July 23, 1887) reports two cases in which no rheumatism had existed. In one, the attack occurred three and in the other four weeks after the beginning of the gonorrhœa. One case resulted in cure, and the other left insufficiency of one of the valves.

SIEGESBECKIA ORIENTALIS is said by Dr. J. Hutchinson (*Brit. Med. Journ.*) to be an excellent remedy for all forms of ring-worm. He applies twice daily equal parts of the tincture and glycerine.

VULVO-VAGINAL CYSTS are often caused by injury during coitus. It sometimes occurs as a result of the first coition, according to Dr. Baer (*Obstetric Gazette*, July, 1887), though some of the cases have a gonorrhœal origin.

The writer recently operated upon a cyst in a married woman which, from its size, caused retention of urine by pressure upon the urethra.

SKIN TEMPERATURE in men between the ages of twenty and thirty has been found by Kunkel (*Phys.-med. Gesellsch.*, z. Wurzburg, 1886) to vary from 31° C., the temperature of the skin of the face, to 24° C. at the tip of the nose and lobe of the ear. Upon the trunk covered with clothing the skin showed a temperature of 30°–32° C., while the skin of the foot was 26.5°–28° C.

CANCER OF THE BLADDER.—Recognizing the immunity of the system at large in cases of cancer of the bladder, Professor Novaro, in the hope of devising a radical operation by which the sufferer could be permanently relieved, has conducted a series of experiments upon dogs. These showed the

feasibility of attaching the ureters to the rectum, thus doing away with the bladder as a functional organ. Although the results in man might not be so favorable, still there is a chance that with improved methods in surgery the disease will be amenable to this radical operation.—*The Epitome*, August, 1887.

MOIST ANTISEPTIC DRESSINGS, frequently changed, form the most essential part of the local treatment of the initial sclerosis of syphilis. Dr. Gerster (*Ont. Med. Assn., Epitome*, August, 1887) directs his patients to provide himself with a wide-mouthed one-ounce vial, which is filled with small square pieces of lint or gauze, over which is poured a moderate quantity of a one per cent. solution of carbolic acid or a 1.5000 solution of corrosive sublimate. The cork-stoppered vial can be carried about by the patient and the sore or sores dressed at least once every hour, oftener if the discharge be very profuse.

Morning and evening a prolonged local bath of the same solution is advisable. In many cases this plan will be sufficient to check the extension of the ulcer, and bring about cleansing of its bottom.

ACNE IN THE AGED has a tendency to become transformed into epithelioma, says Dr. E. Besnier (*Journal de Médecine*, June, 1887), and should not be neglected, as is often the case. Accumulations of fatty crusts are frequently seen in aged subjects with acne of the face, which become more and more solid, and, when they fall off, disclose a canceroidal ulceration more or less extensive. This complication is seldom seen in those who have cleanly habits. The fall of the crusts should be aided by the application of oil, or by washing with soap, or, if necessary, by the application of the thermocautery. If the canceroid is already formed, it should be extirpated, if the operation is practicable, and the small epitheliomata which habitually form in the neighborhood be carefully destroyed. The ulceration may be disinfected with antiseptic washes, and permanently dressed with a solution of chlorate of potassium, which same drug may be administered internally in the daily dose of one grain or less.

HYPERTROPHY OF THE LIPS, and particularly of the upper lip, according to the same writer, is often met with in infants and young children affected with a coincident light eczema of the nares and frequent attacks of coryza. This hypertrophy is difficult to treat, and may reach considerable proportions. The treatment consists in remedies directed against the eczema, and in compression. This combined treatment is accomplished by the application to the lip of a caoutchouc band, fastened behind the head. In this way, more or less energetic compression can be maintained during the night, and possibly during the day as well, until the hypertrophy is reduced.

PICK'S SCARIFYING KNIFE.—Professor Pick recommends a five bladed scarifying knife or Lupotome, which has an advantage over similar instruments which have been recommended, in having only the middle blade fixed, and the two on either side so arranged that they can be taken off. In this way the blades can all be readily cleansed and disinfected.

The blades can also be placed at a distance of a half or a quarter of a centimetre from each other.—*Centralblatt für Chirurgie*, No. 21, 1887.

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JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

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VOL. V.

NOVEMBER, 1887.

No. II.

Original Communications.

AN INTRODUCTION TO THE STUDY OF THE INFLUENCE OF DIET
IN THE PRODUCTION AND TREATMENT OF SKIN DISEASES.¹

BY

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THE question of diet in the etiology of cutaneous disease has always been regarded as important. Most writers on dermatology speak of it as such in their general discussions of the subject, and in relation to the causes and treatment of many individual affections. The medical profession at large also looks upon the subject as a most important one, as shown by their occasional published statements, and especially by the advice given to their patients. The public, too, holds a similar opinion, even a stronger one, as manifested by the universal questioning with regard to the supposed connection between this or that article of food and the cause and cure of the various affections about which we are consulted. The subject is one of ancient and immediate, as well as of universal interest,

¹ Read at the 11th annual meeting of the American Dermatological Association.

and it will be my simple object in this brief paper to enquire what we really know about it.

How may this be best arrived at? Shall we adopt in some measure the views which prevail among mankind in general, on the ground that such popular beliefs must rest on some positive foundation? Shall we accept generally entertained opinions of our profession unquestioned with regard to certain particular articles and whole classes of food, as reliable deductions from prolonged and trained observation? Shall we feel assurance that we may find finally in the writings and publicly expressed statements of dermatologists of all nations, a body of experts from which there should be little occasion to appeal, a satisfactory consensus of opinion, and some well-established knowledge? Let us analyze the information furnished by these sources:

1. *Popular views.*—It might be assumed that man, approaching with infinitesimal slowness toward his present state of civilization had retained in some measure that so-called instinctive part of his early nature, which, it is believed, enables the animal to discriminate between the harmful and the good in its natural food supply, and that in the ever-widening sources from which this has been derived, from his savage state upwards, a protective judgment founded on experience in this direction would have been evolved to a proportionate extent, so that now the accumulated and recorded evidence of individuals would have established a positive basis of distinction between the harmless and the injurious in relation to the causes of all diseases, certainly of those of the skin, the morbid changes in which are exposed to the eye of every one. It would be needless to seek backwards for the germs of such views among the savage tribes of the past, for mankind of many differentiated stocks exist upon earth to-day in their most primitive state, and under the widest differences of dietary conditions, and their customs and their diseases have been studied and recorded by numerous and careful observers. The savage has learned everywhere by experience to distinguish between what is good for food and what is dangerous to life in the vegetable and animal kingdoms, but his observations have gone much deeper and taught him the remedial virtues existing in many plants, as well as their virulent principles, which he extracts for his use. Skin diseases have been found to exist among all savage tribes and under the widest range of diet; the root-digger, the blubber and raw-meat eater, the exclusive fish eater, the strict vege-

tarian, etc., but waiving for the present the consideration of how far such peculiar or such restricted forms of diet may have to do with the causation of these diseases, it may be stated that no evidence exists that the occurrence of these affections has been attributed by the savages themselves to their customs of eating. It is among civilized nations, those amongst whom we live and practice our calling, that we find firmly held opinions concerning the relations of certain common articles of food to the occurrence of skin diseases; upon the broader question of classes of diet they have no fixed views. It is difficult to determine, however, how far such opinions, whether right or wrong, are self-formed, or are the relics or reflections of those previously or at present held by physicians. But it is astonishing to see how few are these articles, about which any widespread beliefs or prejudices exist, judging by one's personal observation in the matter. They may be enumerated in a very small compass.

Butter is generally regarded as a creator of "humors." In a great majority of the cases of the more common affections of the skin, especially eczema and acne, I am asked if it is not bad for the disease, or if it should not be prohibited, or I find that its use has been forbidden to the patient by some household authority. So general is this belief in all portions of the country from which my patients are drawn, that I always try to anticipate such enquiry by stating in my directions for treatment that butter may be eaten in unlimited quantity. It is difficult to determine how such a prejudice against this substance could have arisen and been perpetuated, unless its former use in a "strong" or rancid state, or its entering into the composition of so many "rich" and indigestible dishes, or its employment as a frying medium, may have given rise to disturbances of digestion, but under these conditions it is no longer butter. It may be stated without exception that uncooked butter is a perfectly harmless food, so far as the skin is concerned.

Oatmeal forms an essential part of breakfast of a large proportion of the inhabitants of the northern United States and Canada. It is raised for this purpose in vast quantities here and imported also from Scotland. It is eaten in the form of porridge and cakes chiefly, with the addition of milk, cream, sugar, molasses, or butter. It is commonly believed to be "heating," to be the cause of eruptions, and is often abstained from under this fear by those who have skin diseases. Is there any foundation for this belief? I know none. It is eaten by

vast numbers of people from infancy upwards, who never exhibit the slightest disturbance of the skin; and the cutaneous affections, in the causation of which it is so often regarded as a probable factor, are those of the most common occurrence among all classes and races, including those who never use it. I have for years sought for an explanation of this prejudice among my patients who entertain it, but I have in no instance found a reason why any individual should hold it. I have repeatedly looked for some effect in removing it from and adding it to the diet of patients with affections, which it is supposed to influence, but I have never seen the slightest ill result from its free use. I believe it to be entirely harmless in itself. Of its supposed value above other cereals in the dietary table, it is unnecessary to speak.

Buckwheat.—This seed of *Fagopyrum esculentum*—a polygonaceous plant introduced from Europe—forms at certain seasons of the year a favorite article of food, especially with the young. This is to be explained by the custom of obscuring its disagreeable taste by mixing it with other meals, and by smothering it in sugar, syrups or molasses. It is commonly looked upon as promoting the production of certain skin diseases, especially acne. I doubt if it have in itself any direct action of the sort, but it is not unlikely, considering that it is fried in fats, that it is mixed with all kinds of “raising” substances to make it “light,” that it is eaten in haste while hot, that with it great quantities of saccharine matters are consumed, that the buckwheat cake may aggravate, or possibly even give rise to, acne pimples by producing disturbances of digestion in those disposed to the disease.

These may be taken as examples of the popular prejudices which generally prevail concerning certain articles of diet. The list might be slightly extended, and no doubt similar views concerning other common foods exist in other parts of our own and other countries, alike groundless and inexplicable. Who can suggest for example a reason for the popular belief that tomatoes are a cause of cancer? Yet this *vox populi* rests upon just as real data as any evidence which exists to sustain these other beliefs. For many of them our profession is directly responsible, and they are in fact still openly upheld by it.

2. *Professional Theories*.—It would be impossible, as just stated, to distinguish the views held by the laity upon this subject from those which have originated in and are still maintained by the profession in general, and just as impractical

would it be to attempt to specify what are the loose and crude theories held by the latter, and what the well-founded opinions which have been adopted on the expert authority of dermatologists, for it is doubtful if any such of wide acceptance exist. I have examined the chapters on etiology in all recent general treatises on skin diseases, and it is surprising to see how little, beyond what is vague and unproven in this direction, they contain. In connection with those on the causes and treatment of individual diseases more specific statements are occasionally made, but even upon these points opinions differ widely, and are with few exceptions unsupported by any presentation of evidence. Among writers of different nationalities a very great diversity of views exists. A few examples will best illustrate this most unsatisfactory state of our art.

Fish is looked upon as a suspicious or positively dangerous food in all skin diseases by nearly all patients, by physicians generally in many cutaneous diseases, and prohibited in a few affections by some dermatologists. How much truth underlies these views? Who among us can state that he has observed a single instance in which it could be scientifically demonstrated that it had directly produced a disease of the skin, or aggravated or interfered with the cure of one already existing? Possibly the law of exceptions would rule here to the extent of recognizing that fish may, at times, irritate individual stomachs and thereby provoke a fugitive erythema or urticaria, but so will other articles of food. A distinguished practitioner and well-known dermatological writer of France tells his patients with eczema that they will continue to have the disease as long as they eat fish, and that they cannot recover unless it be abstained from; in other words, he believes that eating fish causes eczema. Is this a fact? There are certain ways by which this question might be satisfactorily answered. Is it known that persons who occasionally or daily eat fish as part of a mixed diet are more liable to have eczema than those under similar conditions of life who seldom or never eat it? Are nations that live largely or exclusively upon fish more liable to eczema than those that rarely eat it? Or, stating it in another way, do maritime peoples have eczema more than those inhabiting the interior of continents? Has eczema become more prevalent in our inland states since fresh fish has been distributed to them so profusely under the recent system of rapid transportation? Do patients with eczema, those in whom it is supposed to have been produced or aggravated by fish-

eating, recover by the simple omission of this diet alone? Do not, in fact, patients recover from eczema who continue to eat fish? And how can the physician who believes that they do not, know that his patients recover more rapidly, or in larger proportion than those who are permitted to eat it? Does he treat a series of cases upon fish diet, and another without it, but otherwise identically? When information upon all these points has been satisfactorily rendered, then I shall admit that an authoritative opinion upon the question may be formed; so far as my personal knowledge covers them, it leads me to the opposite conclusion that there is no evidence that the eating of fish causes eczema, or interferes with its favorable course under treatment.

So, too, with regard to meat. A general opinion may be said to prevail in the profession that meat is at least to be avoided in the diet of patients with inflammatory affections of the skin, and there are some dermatologists who ascribe to it an important agency in their causation. We find statements by them in this direction expressed in the most positive terms, as if the question had been settled by experimentation, the methods of and deductions from which were open to the judgment of all. Is it not strange that in the absence of any such presentation of evidence all sorts of views should be expressed in the discussion of the subject, as positive against as for, according to the training, residence, etc., of the individuals taking part in it? Is it likely that the physician practicing among the exclusive beef or mutton eaters of certain parts of the world should hold the same opinion as to the causes and treatment of eczema, for instance, in this regard, as his confrere among the rice eaters of India? Should any one in the land of mixed eaters attempt to form or express an authoritative opinion upon this point without regard to the data to be derived from both these sources? Not many years ago a well-known writer upon skin diseases, A, proclaimed that psoriasis could be cured by an anti-meat diet. This method was undoubtedly tried by many who found in it nothing to warrant a farther trial. More recently a similar paper, by B, has appeared, strongly advocating the treatment of the same disease by an exclusively meat diet. If either of these publicly expressed opinions be correct, the other is of necessity without foundation. It is not my present purpose to show that both are probably incorrect, but to call attention to the faulty methods and insufficient evidence on which a large part of what is written concerning the therapeutics and dietetics of

cutaneous diseases is based. If A were in absolute charge of a skin ward of a hospital, and would report the changes which took place in twenty or more cases of psoriasis during a six months' residence under an exclusively anti-meat diet, without the use of any therapeutic measures, externally or internally employed, the patients presenting the usual varieties of the disease according to duration, extent, intensity, etc.; and B under similar circumstances would observe the effect of an exclusively meat diet, we might derive from the publication of such results some positive knowledge. But A and B are not entitled to form independent opinions; their experience must be combined.

Another faulty system of theorizing has largely prevailed among dermatologists in the therapeutical relations of the subject. To the firm believer in diathetic etiology, the selection of a dietary consistent with such belief is both an easy task and a necessity. If eczema, for example, is to him merely a local tissue expression of gout, and he finds in the treatises upon this disease, a table of articles of food to be avoided, it becomes a very simple matter to draw the conclusion that these substances also give rise to eczema, and are to be prohibited in its treatment. Of course, there should first be established the connection between these two affections by evidence that all reasonable students can accept before any judgment can be formed as to a common system of dietetics for both. In fact, the ratiocination upon this question is often as follows: Dr. X, a distinguished physician, tells his patient with eczema that his diet and treatment are to be so and so, because his disease arises from the fact that he is gouty. The patient says, "Why, I never had a symptom of gout in my life." The doctor replies, "That makes no difference; you must have gout, because otherwise you could not have eczema."

Methods of Study.—Until proper methods of study are generally recognized and insisted upon, and such narrow and fallacious systems of reasoning are abandoned, I believe that we shall make no advance in the dietetics of skin diseases, and that no writer, however eminent otherwise as a dermatologist, should be regarded as authority upon this question. In what way should we, then, approach this study? As a science of even general dietetics can hardly be said to exist, the study in the beginning must be of necessity largely empirical. First, we may endeavor to ascertain through reliable travelers, missionaries, many of whom are educated in medicine, and resident

physicians, what diseases of the skin prevail in extraordinary frequency, severity of type, or unusual form among tribes or communities, where a restricted diet of any kind has been long followed. Thus, among the natives of the northwest coast, fresh salmon forms the only food for several months, and dried or smoked salmon the exclusive or larger part for the rest of the year. The Eskimo lives almost wholly on blubber and raw meat, and other Northern people mainly on pemmican. The inhabitants of some immense inland plains subsist almost entirely on fresh beef or mutton. Some tribes find their nourishment in the milk of animals. Millions of Eastern people have no other diet than rice and a little fat. Other forms of starch eating are the potato of the Irish, the oatmeal of the Scotch, the macaroni of the Italians, and the *poe*, taro, yams, etc., of Pacific Islanders. The Grahamites and vegetarians amongst ourselves afford scattered individual examples of diet, with but little animal and no flesh food. Many other well-known instances of exclusive and peculiar systems of diet might be mentioned, but these will suffice to show the opportunities which exist for the study of their influence in the causation of skin diseases. Of course, without the fullest information in relation to all the other conditions of life of the people studied, no inference whatever could be drawn from the facts of diet and of skin disease co-existent in any such instance. The uneducated mind drew the inference that salt meat and scurvy associated on shipboard stood in relation of cause and effect, the absence of the lime juice or its equivalent, as the real etiological factor, was not appreciated. Let us beware that we do not observe the same faulty method of induction in attributing similar positive action to any article or class of foods in our study.

Another enquiry of value would be, What change in the type or character of skin disease has accompanied the introduction of new diets among nations of advancing civilization, or what new cutaneous affections have followed thereon? This should be conducted with the same care to exclude the manifold errors which would surround a partial investigation of the question.

From such difficult and broad ethnological questions we must descend to the more limited fields of research afforded by individual cases, open to all dermatologists in some measure. It is only those who are fortunate enough to have direction of large wards for the care of cutaneous diseases, however, who can carry on experiments upon these points with satisfactory

exactness, and whose results can be received without serious questioning. How or where, outside of such establishments, can any physician carry out any practical scheme of testing the effect of variations in food, or of any restricted system of diet upon the aggravation or amelioration of a skin disease? Where else could he hold control of a patient long enough for such experimentation without the necessity of introducing into the case the complication of simultaneous internal or external medication? No; the conclusions of every dermatologist upon such points, drawn from observation of peripatetic dispensary or private practice, however extensive these may be, are to be regarded as of comparatively little value, as a rule, on this account. He may at the most say: "I cure my patients in this and that affection, on this or that diet, more quickly and easily than I formerly did on different diet;" but it would be essential, before accepting such statements as in any way conclusive, to know that no change whatever had also been made in the therapeutics employed then and now. Unless a minute and complete report of both series be furnished for analysis, any conclusions offered may fairly be regarded as impressions, not as proofs. It is not at all strange that opinions based upon such methods of study should forever be met by like but antagonizing statements of other observers. I would not be understood as meaning that the observations of the individual dermatologist are of no value, only that sweeping conclusions are generally of this character.

Laxity exists, too, in the meaning of terms used in classifying so-called injurious articles of food. There are some which may be of themselves directly provocative of cutaneous disturbance, and there are others which act only indirectly upon the skin by first disturbing some other parts of the economy. If an indigestion may cause abnormal action in the integument, and some article of food give rise to the former alone often, and never to the latter without the gastric disturbance first, then such a food cannot be said to be primarily or directly the cause of the change in the integument. Clams for example, when eaten by some persons, produce symptoms of severe gastric irritation, and in a certain percentage of these a subsequent disturbance of the skin more or less general. This latter action is no doubt sometimes the result of the impression primarily produced upon the stomach, and the dermatosis is indirect and secondary. But if meat is spoken of as causative of cutaneous disease, such effect, if true, is inexplicable by such action on its part, for it is not claimed that it produces indigestion. Fish, when boiled or

broiled, may be eaten with impunity, but, when fried, may give rise to disturbances of the digestion and the skin. It is not the fish which has provoked the trouble, but the overheated fat incorporated with it. It is important, therefore, in discussing the relation of foods to the etiology of skin diseases to recognize such distinctions, and to state as definitely as possible whether articles in question are accused of being specifically injurious, that is of acting in some unknown way directly upon the skin to its disadvantage, or whether they act thus secondarily as promoters of indigestion, or by otherwise disturbing the economy.

I know no better way of approaching this individual method of study than to endeavor to state simply my observations concerning some articles of food which have seemed to me to be in any way injurious to the skin. subject, of course, to the criticism of individual opinions above stated. I shall not attempt to explain how they act, because in most instances I do not know, nor shall I try to classify them on any physiological or chemical basis. My black list is small, as will be seen.

Alcohol.—For my present purpose I shall consider this to be a food. There is no older or more widely held popular opinion in connection with our subject than that the excessive use of alcoholic drinks paints itself upon the face of man. The flaming portrait by which Shakspeare has immortalized the countenance of Bardolph, the tavern talk of successive eras of writers, and the expressions so commonly in use at the present day, “grog blossoms,” “toddy blossoms,” etc., are sufficient illustrations of it, and yet many a bearer of a “jolly red nose,” who has never used alcohol at all, suffers the false judgment of his fellow-men. There can be no doubt that excess in alcohol drinking may give rise to a permanent enlargement of the facial capillaries, indicated by a diffused hyperæmia of varying shades of redness, and by a visible enlargement of individual twigs, but how far it is directly accountable for the follicular inflammation and elephantiasis of the parts, which at times accompany this angioma, is somewhat doubtful. Professor Hebra used to say that he could distinguish between the brandy drinker and the wine drinker, even between those who drank Rhine and Austrian wines on the one hand, and those who used the stronger vintages of Hungary, Spain and Portugal, by the appearances of the face. But besides these tendencies to rosacea on the part of those who drink too freely, so well understood, I have noticed other changes in the skin from the effects of alcohol. I often see in my out-patient department at the hospital persons

of both sexes presenting excessive grades of dermatitis in the form of diffused impetiginous, ecthymatous, and even furuncular efflorescences, sometimes generalized, but mostly confined to the limbs, especially the lower legs, which exceed in the intensity and depth of the inflammatory process all ordinary forms of acute dermatosis. So characteristic are these appearances that I am seldom disappointed in the reply when I ask if the patient have not recently been drinking spirits in excess. They generally follow a spree of several days' duration. I have known lager beer in a great many instances to produce acne about the lower face, chiefly in women. So susceptible are some persons to this action that a single glass will be followed within twenty-four hours by a moderate crop of small pimples on chin and cheeks. It would be wrong, however, to ascribe this effect to the alcohol positively, because beer contains so little of this and so many other elements, and an equivalent amount of wine fails to produce it in such persons. There can be no question, too, that alcohol greatly aggravates the intensity and course of most inflammatory affections of the skin, both by quickening the cutaneous circulation and by its stimulating presence in the capillaries of the affected parts, so that its use in such diseases should be strictly forbidden.

Acid Fruits.—I feel sure that at certain seasons acute eczema is produced in some persons by eating fruit containing abundant acid. I have noticed this during strawberry season, and later at the time of the ripening of pears and grapes. So noticeable is this action of strawberries, that I expect a decided increase in the number of my patients with eczema in June. The type of the inflammation is generally erythematous and papular, in patches or diffused, but it presents no peculiarities in seat. The proportion of persons affected in a similar way by the autumn fruits above mentioned is not so large, but I think there can be no doubt of such occasional action on their part. I have repeatedly observed an aggravation of an existing eczema when they were eaten, and always forbid their use in this disease. I have not recognized any such injurious effects from eating any other fresh fruit, native or imported, even in the most acid lemons and oranges.

Strawberries, moreover, often excite an urticaria, as is well known. Many persons cannot eat them at all without the most violent agitation of this kind ensuing. They are sometimes very freaky, however, in this respect, of which my own experience is an illustration. While traveling in Switzerland, thirty

years ago, I found myself, for the first time in my life, a victim of urticaria. It recurred frequently, before I discovered that it always followed the eating of wild strawberries. During my boyhood, passed in Maine, I had only eaten the wild fruit, and always without bad results. On my return, the next season, I visited Maine again, and ate the native berries without harm, and supposed that possibly some peculiarity in the Swiss species was the explanation of the cutaneous disturbance. Ten years later there was a summer when the cultivated fruit repeatedly produced an urticaria upon me, although they had never done so before, nor have they since then. Four years ago I was again in Switzerland, and ate the native berries from curiosity, for they were far from agreeable to the taste, but they produced no visible effect upon my skin. So variable is the action of strawberries or individual susceptibility to their influence.

Apples sometimes produce, especially in those liable to follicular inflammation, an acniform efflorescence about the mouth. In children a larger form of eruption, clustered vesicles or shallow, impetiginous or ecthymatous lesions upon the lower face, resembling some kinds of so-called impetigo contagiosa, is thought to result from apple eating. This affection is well known in the country in late summer and autumn, and is called "apple humor." Sweet cider is supposed to produce similar effects. I do not mention this action of apples as positively demonstrated, but as worthy of observation.

Nuts.—It is well known that some nuts, especially the European walnut, produce an irritation of the lining membrane of the mouth in many persons. They may also give rise to herpetiform inflammation of the lips and bordering skin, and sometimes produce an acne, due no doubt to their indigestible nature when eaten in excess.

Shell-fish and Crustaceans.—Lobsters, crabs, mussels, oysters, clams, etc., all occasionally give rise to urticaria, but in fact rarely, when we consider in what vast quantities they are eaten. Some persons can never eat them in the smallest amount without being thus affected; in others the effect sometimes follows their ingestion and sometimes does not; while the majority of mankind may eat them always without harm. This action is not necessarily dependent upon the degree of gastric disturbance produced by them, for this is often excessive without the slightest cutaneous irritation, and more often the urticaria is developed with no perceptible symptoms of indigestion accompanying.

There are other meats which exceptionally produce similar effects, the skin or stomach of everybody apparently having their individual *bête noir*. One of the few instances of giant urticaria I have seen was a gentleman who, during two or three years of his life, could not eat the least bit of roast turkey without having an urticaria, sometimes of the ordinary forms, but on several occasions presenting swellings varying in size from a pigeon's to a small hen's egg, and lasting several hours.

I am perfectly aware in how unsatisfactory a way I bring this paper to a close, but its ending is in this respect consistent with the state of our knowledge of its subject, and my purpose and excuse for presenting it in such form are that it may the better illustrate how much remains for us to do to elevate the dietetics of cutaneous disease to its proper position in our special science.

SALT IN DERMAL HYGIENE AND THERAPEUTICS.¹

BY

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THE writer's observations are based on experiences gained by twelve summers' residence at the seaside, and two months recently spent in the salt-making regions of western New York. During these periods he has carefully watched the effects of salt water on both the normal and diseased integument. Before referring to these, however, it will be well to consider the composition of sea water and of the natural brines met with in the interior of the country.

Sea water varies slightly, both in strength and composition, in different parts of the world, but on the average contains about 2.5 per cent. of salt. Many of the brines from the interior contain as much as 25 per cent., and none of them from which salt is manufactured contain less than 15 per cent. Salt is obtained from sea water by solar evaporation, and is produced in large quantities at Turk's Island, in the West Indies, and at various points along the shores of the Mediterranean Sea. Salt thus obtained is met with in commerce in large, hard crystals, more or less discolored by various impurities, and is

¹ Abstract of a paper read at the meeting of the American Dermatological Association, September 1, 1887.

commonly known as sea salt. It usually contains about 95 per cent. of chloride of sodium, together with a varying, but small, quantity of magnesium chloride, magnesium sulphate, sodium sulphate, calcium sulphate, etc. It is commonly supposed to contain iodine and bromine, or some of their compounds, but this is probably an error. Sea water undoubtedly contains a trace of iodine, but analysis fails to show its presence in commercial sea salt.

Sea water and sea salt, however, contain a peculiar ingredient to which little attention has heretofore been paid. I allude to a certain glutinous principle of organic origin concerning which Ore¹ says: "We find in all sea waters a principle which is not referred to in the majority of chemical analyses and the importance of which should not be overlooked. This principle, the organic element of sea water (*mucosité de la mer* of Bory de Saint-Vincent), belongs to the group of organic substances and is analogous to the coagulable substances of living bodies, but, like casein, is not coagulated by heat. This principle exists chiefly, according to Roccas, in those parts of the sea which abound in animal and vegetable life rather than along the barren beaches. Is it an exudation from the algae which largely contain a glutinous material, or is it the product of the putrefaction of dead animals and vegetables? This is a question that we are not at present able to answer."

The effects of sea-bathing vary greatly with the circumstances under which the baths are taken. A plunge into the sea at a temperature of 60° to 70° causes an immediate chill usually of but brief duration, as the exercise of swimming soon produces reaction and the chill is no longer felt. After twenty minutes or half an hour, if the bath be continued so long, a second chill comes on, due to the gradual but certain abstraction of the bodily heat. This chill persists and becomes intensified as long as the subject remains in the water. On emerging, the bather usually experiences a sticky or clammy feeling on the skin, due to the slime of the sea already alluded to; and this is to many so disagreeable that they sponge or wash off in fresh water before resuming their garments.

The general effects of a bath of this sort vary with the vigor of the subject, the temperature of the water, the duration of the immersion, etc. Those in robust health who are sufficiently prudent to leave the bath before the advent of the secondary chill, and then dress promptly, may derive benefit and renewed

¹ Nouveau dictionnaire de Médecines et Chirurgie, T. ix.

vigor from the experience. If, however, the bather is in feeble health, the sea-bath as ordinarily taken, is very apt to result in harm rather than good, mainly in consequence of the abstraction of the animal heat by the water, which is usually from 20° to 30° F. lower than the normal temperature of the body. The local effects on the skin coincide in great measure with the general effects. In a vigorous person, a sluggish eczema or a psoriasis will exhibit decided signs of activity, usually in the right direction, provided the water has been decidedly warm (for sea water), and the bath of short duration, followed by vigorous use of the towel and speedy resumption of the garments. If, on the contrary, the patient be feeble or the bath be too prolonged, the effect will be unfavorable, not only on the general condition, but in its local effects, reparative processes being retarded.

The cutaneous affections that in my experience have derived the most benefit from a systematic course of sea-bathing conducted with prudence and good judgment are chronic eczema, sluggish psoriasis, and the summer eruptions, such as prickly heat, furunculosis and in general, pruriginous affections.

Almost universal experience has demonstrated the advantages to be derived from sea-bathing, in strumous diseases, and we may well believe that strumous affections of the skin respond favorably to this agent. The so-called *scrofulides benignes* of Basin certainly do; but with the *scrofulides malignes* the natural changes are so slow that the effects of an ordinary course of sea-bathing are hardly perceptible. In some cases of lupus there is an associated tendency toward pulmonary tuberculosis that should guard us against too free exposure to the moist air and often raw winds of the ocean.

To derive benefit from sea-bathing it is essential that the water should be comparatively warm and the surrounding air soft and balmy. The duration of the bath should be brief and never prolonged until the secondary chill appears. Free friction on emerging and speedy resumption of the clothing should be enjoined.

Unfortunately sea-bathing can be pursued, in this latitude at least, for but a few weeks only during the months of July and August, and in chronic affections should be supplemented by salt water baths at home, that is, if the greatest amount of good is to be obtained; as the best effects from salt water bathing are rarely noticeable except the baths be continued for several months. To this end sea salt may be employed at home, with

such frequency as may be desired. A bath containing five pounds of salt to twenty-five gallons of water will be about equivalent in strength to sea water. Baths from sea salt I have employed to a limited extent only, as the salt is hard, very slowly soluble and more or less dirty and is sold at the drug stores at a ridiculously high price. Baths from sea salt leave the same disagreeable sticky sensation on the skin that follows the use of sea water.

Turning from sea-bathing and the use of sea salt to natural and artificial brines made from white salt, I come to a branch of the subject which has interested me greatly during the past three years. During the period named I have used both personally and on patients baths containing from one-half per cent. to 25 per cent. of salt. The ordinary bath-tub when filled to the usual point holds about twenty-five gallons of water, and a pound of salt added to it would represent the first percentage, and fifty pounds of salt the second. In the first instance, that is, with the addition of a single pound it is hardly possible by the senses to distinguish any difference between it and an ordinary bath of fresh water, so far as its effects on the normal skin are concerned; but when we quintuple the quantity of salt bringing the strength up to that of sea water we will certainly notice the different sensation it conveys to the skin. The water now seems to possess a peculiar softness and glides over the skin, seeming to wet it more easily than plain water, the feeling being very similar to that produced by water in which a small quantity of salsoda has been dissolved. On emerging from the bath one experiences a sensation of exquisite cleanness, unaccompanied, however, by the dryness and harshness of the skin that follows the use of soda or strongly alkaline soaps. If you increase the salt to ten pounds to the same quantity of water these sensations will be intensified and the skin will seem to acquire an almost preternatural softness and flexibility. These effects be it understood are to be expected when the temperature of the bath is high, say from 95° to 97° F. and the immersion continued for fifteen or twenty minutes accompanied with moderate friction with a coarse linen towel or soft brush while in the water.

White salt here referred to is that obtained from the natural brine wells in the interior. It should be of coarse grain and readily soluble. It differs from sea salt in being purer, containing from 97 to 98 per cent. chloride of sodium. It is cleaner, making a clear solution, instead of one more or less turbid, and

is free from the disagreeable scum present when sea salt is used. It will dissolve in one-third the time required for sea salt, and can be obtained at one-third the cost. These features make it much nicer to use, but popular prejudice is in favor of sea salt, owing to the mistaken notion that the latter contains iodine, etc. To meet this, manufacturers have been known to artificially color white salt with decoction of tan bark, and even to mix with it a small quantity of earth to make it resemble the really less desirable article.

During the months of April, May and June of the present year, I employed this weak 5 per cent. brine for ordinary bathing, using, of course, no soap, and found that, as a cleansing agent, it was fully equal, if not superior, to the usual soap and water. It removed the bodily odors and exuviae from the skin, as readily as soap did, and far more thoroughly. Further, the axillae and other hairy parts remained sweet and clean and free from odor for a longer period than would have been the case after the most thorough use of soap.

This cleansing and deodorizing effect of salt in 5 per cent. solution was entirely new to me, and appears to be an exceedingly valuable feature. Another point in favor of the 5 per cent. brine bath is the fact that the skin exhibits a softness and suppleness that I have never experienced from any other form of bath, be it Turkish, Russian or Roman. Soda is equally effective in these respects, but tends to make the skin dry and harsh. Considered purely as a luxury, the brine bath is to my own taste to be preferred to the baths above mentioned, and with the added advantage of being cheaper and readily obtainable at home.

I have experimented also with baths containing 10 per cent., 20 per cent. and 25 per cent. of white salt. As regards the 10 per cent. baths, it did not seem to me that the effects differed sufficiently from the 5 per cent. bath to make it worth while to use this greater strength. During July and August of this year I took about twenty baths with the salometer standing at 80° to 100° indicating strengths from 20 per cent. to 25 per cent. The bath-tub was of specially large size, holding about 100 gallons, and was supplied with saturated brine from large storage tanks connected with one of the extensive salt manufactories in western New York. There was also a pipe which supplied hot fresh water. By these means it was easy to secure any desired temperature and strength of solution. The strength generally employed was 20 per cent. On entering a bath of this descrip-

tion one is surprised by the extreme difficulty of reaching the bottom of the tub, such is the buoyancy of the water! In fact, with the body completely extended and quiescent this is impossible, and apparently one-fifth of the body remains above the surface. While in the bath the water feels soft and pleasant, and is in no wise irritating except to a mild degree to the mucous membranes. A peculiarity of the saturated brine is the difficulty with which it wets the skin. On emerging, the fluid rolls off almost like water from a duck's back, leaving here and there a few adherent drops. Passing the hand over the surface removes these, and a towel was entirely unnecessary and never employed, the garments being immediately resumed.

In the treatment of cutaneous diseases I have found weak brine baths of essential service in not a few cases. In acute moist eczema it is well known that a bath in plain fresh water, with or without soap, usually aggravates the local lesions, due, I believe, to absorption of water by the exposed malpighian cells. If, however, from half a pound to a pound of salt be added to the bath (twenty-five gallons), these effects will in great measure be obviated, and the patient will state that his skin feels better after than before the bath. Thorough cleansing of the surface may thus be obtained without the usual inconveniences.

In sub-acute eczema, in psoriasis, in furunculosis, in irritable summer rashes, whether of a papular or pustular character, in urticaria, and in various forms of scrofulosis, and in pustular and ulcerative syphilides, the 5 per cent bath (ten pounds of salt to twenty-five gallons of water) is to be recommended, not only as a great source of comfort to the patient, but as unquestionably a therapeutic agent of great ability.

In prescribing these baths, I usually direct that the water be as hot as could be comfortably borne during an immersion of fifteen to twenty minutes. Cold brine baths, sponge baths, etc., I have experimented with too little to enable me to arrive at any conclusions whatever.

While attention is here chiefly called to the local effects of brine baths, their influence on the general health is not to be overlooked. In most instances a course of twenty to thirty baths, taken daily, or thrice weekly, has been followed by manifest improvement when there was previous impairment of the health. On the other hand, I have never noticed any ill effect from their use.

THE CLASSIFICATION OF SKIN DISEASES.¹

BY

EDWARD BENNETT BRONSON, M.D.

(Concluded from page 381.)

PLAN OF THE CLASSIFICATION.

CLASSES.—Assuming it to be established, then, that the primary divisions of cutaneous diseases should be anatomical, we have to inquire what are the anatomical parts of the skin which, having a distinct structure and function, are susceptible of peculiar morbid perversions? They are easy to fix. They consist of (1) the epidermis, (2) the follicles and so-called appendages of the skin, (3) the connective tissue of the derma and subcutaneous areolar structure, (4) the nutrient vascular apparatus and (5) the nervous apparatus.

Each of the above-named divisions has a more or less independent character, and to each appertains an independent train of diseases. Many affections, it is true, may involve more than one of these divisions, more especially where those apparatus are concerned which furnish the means of communication with the system at large, as the nervous and vascular. Thus nervous affections may be attended with local trophic changes in the skin extraneous to the nerves, and, likewise, vascular and circulatory disorders may be associated with various morbid alterations of the adjacent parts. But where the morbid action becomes specially localized in a particular tissue or structure, so as to produce a typical process, it is the peculiar susceptibility or aptitude of this structure that becomes the major consideration and is the more general, and hence the major factor in the etiology of the disease. It is only where the nervous or vascular influence remains independent of any typical tissue change that the affection becomes entitled to a position in a distinct major class. With regard to the neuroses the only ones so entitled are such as are attended simply with alterations of sensibility or motility. Such affections have been aptly termed by Auspitz “*idioneuroses*”—neuroses pure and simple. It is the “*Idioneuroses*” of the skin that constitute my first class.

To the vascular system belong as a major class only such affections as pertain purely to its circulatory and nutrient functions without specialized tissue derangement. “*Angioses*”

¹Read before the American Dermatological Association, 11th annual meeting, 1887.

of the skin constitute my second class, and are to be defined as disorders of the cutaneous vascular apparatus, or of the cutaneous circulation, and embrace the common effects of engorgement, ischæmia, transudation and inflammation.

The third class is designated "Epidermidoses." Here we have a major division of cutaneous affections which derive a special character from the region which they affect. It includes not only anomalies of growth, but also anomalies of nutrition, among which are certain affections that are inflammatory. An inflammation that has its invariable seat in the mucous layer of the epidermis acquires a typical character that differentiates it fundamentally from all others. The major factor in this differentiation is the anatomical structure, and whether the immediate cause be a local irritation or a remote disease, a vascular engorgement or a central neurosis, the evolution of this specialized form of inflammation is primarily owing to the anatomical factor, and hence the designation of the major class to which this particular form of inflammation belongs should be epidermidosis.

A large proportion of the diseases of the skin take their origin in, and owe a special character to, the cutaneous follicles. They consist of anomalies either of the follicles themselves, of their products, or of both simultaneously. Inasmuch as the cutaneous follicles are evolved from the epidermis they are properly epidermic structures, though in their salient characters widely divergent from the parent structure. Hence an affection of the epidermis may extend *per connuitatem* to the follicles. In such case, the follicular affection would be an epidermidosis simply and very different in character to affections that taking their inception in the follicles exist solely as perversions of functions, nutrition or growth which are peculiar to the follicles. The latter constitute a distinct class of diseases, and have received the appellation, "Cryptoses" (Class IV.). They comprise diseases of the sebaceous follicles and their function, diseases of the sweat follicles and their function, diseases of the hair follicles and of their product the hair, and, finally, diseases of the nail structures. The inclusion in this class of the nail affections may encounter objection on the ground that the follicular character of the nails is indistinctly marked. But between the nails and the hair there are so many marks of resemblance that it is hardly straining the point to assume an analogy between the nail matrix with its multiple papillæ and the single hair papilla, while between the

diseases incident to the two structures there is too close a correspondence to be ignored.

The remaining (fifth) class embraces all those affections of the skin which are the product of the various anomalies of growth of the connective tissue. Auspitz gave to them the name chorio-blastoses or chorio-desmoses, but the simpler appellation "Desmoses" has appeared to me sufficient. In a former classification I included connective tissue inflammations under a separate class, named "angio-desmoses," as I also included epidermic inflammations under "angio-epidermidoses." While for reasons already given the latter are essentially epidermidoses, the former, I have classed with the angioses, inasmuch as they are essentially vascular anomalies without any distinctive characters as affecting the cutaneous connective tissue to distinguish them from connective tissue inflammations everywhere.

It being thus determined what the classes or primary divisions are, it remains to establish the subdivisions of the classification. It is desirable that the plan pursued should be uniform throughout, in that each subdivision in its order should everywhere have a uniform value and significance. The subdivisions consist of orders, tribes, families, species and varieties, any one of which may be still further subdivided. In each of these a distinct basis of comparison is presented, which for that particular subdivision is everywhere the same in kind, while in the different subdivisions the variations express a regular descent from the more general to the particular, from the relatively abstract to the concrete.

Orders.—The orders like the classes are anatomical (or physiological) divisions, but more definite in that they relate in a more particular sense to the anatomical structure or the physiological function implicated. Thus under idioneuroses we have two orders—"sensory neuroses" and "motory neuroses." Under angioses there are three which are physiological, and are divided as follows: "Angioses simplices," relating simply to blood supply, to the presence of anæmia or hyperæmia; "ecchyse," relating to anomalies of transudation, and including the suborders hemorrhagiæ and œdemata; "chromatoses corii," which stands for transudations of coloring matters, and includes the suborders melasmata, dermatocholoses and heterochromatoses and finally, "phlogoses" which comprise certain of those perversions of the nutritive function which we know under the name of inflammation. It includes as a suborder necroses. Epidermidoses em-

brace also three orders, viz.: "Keratoses," "acanthoses" and "chromatoses epidermidis." Under cryptoses the orders also relate to the anatomical seat and comprise "steato-cryptoses," "hidro-cryptoses," "tricho-cryptoses" and "onycho-cryptoses," with their suborders. There are no orders under desmoses, but one structure being involved.

Tribes.—The next subdivision is into tribes which define the nature of the pathological process. The tribes of any major division, while they concern the same kind of structure or the same cutaneous function, serve to exhibit variations in the type of disease. These variations depend on such contrasted processes as pertain either to excess or impairment of nutrition (hypertrophy or atrophy) or to other divergencies from the normal type. Such are the "anæmiæ" and "hyperæmiæ," the "hyperæsthesiæ," "anæsthesiæ" and "paræsthesiæ," the "hyperkeratoses," "keratolyses" and "parakeratoses," and the like. The suborders hemorrhagiæ and œdemata are divided into the tribes "angiopathic" and "hæmatopathic," according as the hemorrhage or œdema is due to injury or disease of the vascular walls on the one hand, or to a morbid state of the blood (hæmotosis) on the other—an important distinction which should be made, though with our present knowledge it is not always possible to make it. Similarly the dermatocoloses (icteric diseases) are divided into "hæmatogenous" and "hepatogenous" tribes. The phlogoses of Class II. are separated into the two tribes "erythemata" and "phlegmatia," which differ from each other not only in that one is superficial, the other more deeply situated, but in that while one concerns the blood vessels more particularly, in the other it is the lymphatics that are chiefly affected. In the last mentioned cases, where the orders are essentially physiological, the divergencies in pathological type expressed in the tribes relate to anatomical factors. The inflammations in the third sub-order of steato-cryptoses are divided according as they are attended with alteration in the secretion (*i. e.*, with the production of comedones) or not, into the two tribes "steato-phlogoses" and "asteato-phlogoses." The desmoses comprise three tribes, viz.: "hyperdesmoses," "adesmoses" and "paradesmoses," the last named being divided into the sub-tribes "granulomata" and "desmomata."

Families.—Again, the type of the pathological process remaining the same, we may often distinguish different groups of diseases in the same tribe, which are clinically distinct from each other, whether the precise nature of the pathological con-

ditions upon which they depend are apparent or not. They correspond generally to the clinical divisions of Alibert, and are designated here as families. Thus under the paræsthesiæ of the second order (anomalies of tactile sensation) the "pruriginous" affections constitute a distinct clinical group or family. Under the erythemata there are three families which differ mainly in their issue or sequel, namely: the *simple* erythemata (corresponding to the "erythema" of Auspitz), in which complete resolution is the result, those characterized by *telangiectasis*—the rosaceous affections, and those which terminate in *atrophy*—the various forms of lupus erythematosus. The phlegmatiae embrace "furunculous," "carbunculous," "erysipelatous," "pachydermatous" and "sclerodermatous" families. Under necroses we have as distinct families the "gangrenous" and "ulcerous" forms. In Class III., acantholyses embrace "pemphigous," "herpetous," "eczematous," "phlyzaceous" and "variolous" families, all essentially affecting the mucous layer of the epidermis, all associated with a process of acantholysis, loosening or separation of the prickle cells, but in different degrees, apparently by different means and in consequence of independent and dissimilar general pathological conditions. As the type of the class may be taken the pemphigous group, the adjective being used in a broad generic sense. In this group the separation takes place most readily, the vitality of the part is most signally impaired, most nearly approaches a condition of necrosis. Similar to this is the phlyzaceous. Next come the herpetous and variolous families, which, though due to remote causes that are widely diverse from one another, are nevertheless of closely analogous type so far as the local epidermic change is concerned. The diphtheritic character of the inflammation in the variolous form is a secondary consideration. In the eczematous affections the epidermic process, though partaking of a similar character, is slight in degree, of slower development, of longer continuance and more diffusely distributed. The families of the IV. and V. classes call for no special comment.

By these divisions the character of the diseases, so far as the morbid process is concerned, should be sufficiently defined. It remains to express their relations to specific, local or systemic causes.

Genera.—These represent etiological groups in the more restricted sense. They take cognizance of those considerations which, in the classifications of Bazin and Auspitz, are made

paramount, but are here put, as appears to me just, in a subordinate position. In many cases the genus is sufficiently specified by the terms "idiopathic" and "deutero-pathic"—one signifying independent local diseases, the other affections secondary to some remote or internal condition. Often it happens that in the name of the species the cause is already expressed. The genera may be indefinitely extended and will doubtless be multiplied considerably as our knowledge of etiology increases. Many of the genera relate to affections of "neuropathic" origin, others to such affections as are due to, and derive more or less peculiar characters from, systemic diseases and are termed "symptomatic." Certain affections that ostensibly consist simply of the cutaneous disease, and are not due to any well-defined local or systemic cause, are termed "essential"—a merely negative expression which, sooner or later, will, without doubt, be replaced by one of more definite significance. The term "endemic" has a similar provisional character. The genera of "parasitic" affections will be found distributed throughout the classification, the so-called mycoses or "tineal" affections occurring especially under parakeratoses, paratrachoses and paronychoses. In the classification here presented the formation of a separate class of parasitic diseases would be superfluous and illogical, and the same may be said of the infectious diseases. A class of parasitic diseases would rightly include not only the superficial fungous affections of the skin, but probably all the so-called infectious diseases as well. Whatever the local affection may be and whatever its cause, the first thing to inquire is—How is the skin affected?—and then—What is the affection due to? The parasite gives character to the local affection and makes it an independent form of disease, but the same morbid reaction in the skin might not possibly be the effect of many other causes.

Species.—These represent the lowest subdivision next to the varieties, and comprise the lowest groups of disease which, so far as their cause and origin are concerned, are independent of each other. They embrace *varieties* representing phases or accidental forms of the same affection which are more or less interchangeable, but the species are practically not interchangeable and almost always preserve distinctive characteristics. Between the species and the genera there is the same kind of distinction as that implied in Bazin's two classes, *Les affections* and *Les maladies*, the affection being the local cutaneous process, the disease the general condition upon which the local affection depends.

In brief the five divisions of the classification may be identified as follows:

The Species denotes the local affection.

The Genus denotes the disease (the pathogenesis).

The Family denotes the clinical type.

The Tribe denotes the pathological type.

The Order denotes the structure or function involved.

The Class denotes the anatomical seat affected.

Though no such object was originally had in view, it is apparent that the above divisions practically embrace all of the considerations enumerated in the beginning, and which it was stated had formed the bases of division in the more important classifications of modern times. It was my aim to construct a system which should exhibit the most essential facts in the genealogy of skin diseases. That incidentally these facts have proved to be identical with those that so many eminent dermatologists have had in view is sufficient guaranty of their high importance. My special endeavor has been to assign to each its due consideration and rank.

Society Transactions.

THE AMERICAN DERMATOLOGICAL ASSOCIATION.

THE Eleventh Annual meeting of the American Dermatological Association was held at Baltimore, August 31 and September 1, 1887.

The Society was called to order by the President, Dr. H. G. Piffard, of New York.

DR. R. W. TAYLOR, of New York, read the first paper which was entitled,

TOXIC EFFECTS OF IODOFORM.

The paper was based upon a study of twenty-five cases, nine of which had come under the personal observation of the author. In nine of the cases, the cutaneous affection was the only evidence of the toxic action of the drug, while in sixteen cases there was constitutional disturbance, associated with the rash. It is evident from a study of the reported cases of iodoform poisoning that the toxic effects of this drug are more frequently manifested by constitutional disturbances than by affections of the skin. It is also found that the drug may set up inflammatory affections of the skin without the presence of constitutional symptoms.

The affections of the skin which occasionally follow the use of iodoform, are according to their relative frequency, erythema, eczema and purpuric spots. The erythema due to iodoform may present many of the features of

the ordinary affection. Its mode of invasion is prompt and its extension rapid. It may commence at the point where the drug is applied, or commencing there, it may be met by the extension of other patches beginning in other parts of the body. Cases have been reported in which erythema has followed the smelling of the drug. The eruption completes its evolution in a few days and under favorable circumstances rapidly undergoes involution. Various forms of erythema have been noted. At times it is very superficial. Again, while still superficial it may present a deep red hue which may be termed scarlatiniform. In exceptional cases, the erythema may in its color and brawny feel, present points of resemblance to erysipelas. This, as a rule, only occurs in cases where there are grave constitutional symptoms. Other cases might be classed under the head of erythema multiforme.

The eczema resulting from the use of iodoform is as a rule severe and of rapid evolution. It may begin at the point of application or at distant points. This also may follow the inhalation of the drug. A large surface is involved from the first and in all respects it is similiar to eczema madidans. The eczema disappears almost as rapidly as it develops, provided the administration of the drug is stopped. Eczema occurred in nine of the twenty-five cases reported.

The time of the appearance of the eruption was noted as follows : in twelve cases it began within a few hours or during the first day ; in two cases on the second day ; in three on the third day ; in one on the ninth day ; in one on the twelfth day, and in two on the fourteenth day. This is in marked contrast with what has been noted with reference to the period of onset of constitutional symptoms. In the vast majority of these cases the symptoms begin in the second week. It may be stated that as a general rule, in proportion as the appearance of the rash is delayed, so are the concomitant symptoms severe. Statistics seem to show that the cutaneous manifestations of iodoform poisoning are most frequent in youth and middle age, while the systemic symptoms occur most frequently in the aged. The erythema appearing upon the hands of those who use iodoform constantly was not regarded as belonging to the condition under consideration. This is more closely related to the ordinary hyperaemia resulting from the action of other irritants, such as mustard, etc.

The practical lessons taught by the collective knowledge of the nature and action of iodoform should be well remembered, and may be concisely stated as follows:

Its use is indicated: On fresh wounds; on diseased surfaces—gangrenous, chancroidal, phagedenic, syphilitic, tuberculous—and on those slow to take on healthy granulation; on the surface of necrosed bone.

Its use is contra-indicated: On freshly-cut bone; on granulating surfaces; in cases in which it is known or is found to produce toxic effects.

Modes of use: It should be dusted on the surface lightly and sparingly; in wound-cavities, or in the natural cavities, as small a quantity as possible should be employed; in the former it is preferable to use it in the form of gauze; it should never be rubbed in with the finger; its application should be renewed as infrequently as possible; such aids to absorption as tightly-fitting bandages and impermeable dressings should not be used; its use should be discontinued as soon as healthy granulations appear; it should not be used coincidentally with any other antiseptics, carbolic acid especially (Mosetig-Moorhof); it should be used with great caution in the young and

the old, in anæmic and neurotic persons, and those suffering from weak heart or Bright's disease; also in very fat and flabby subjects; should toxic symptoms appear, the iodoform dressing must be promptly and thoroughly removed.

The occurrence of anomalous forms of persistent or recurrent eczema in persons who handle or in any way come in contact with the drug, or who use it as an ointment or in suppositories in the vagina or rectum, should lead the physician to suspect the agent as the possible cause.

It is most important that the practitioner should exercise a watchful care over all patients for whom he prescribes this agent, and should he observe morbid symptoms, however mild, pointing to the brain, heart or lungs, or a tendency to loss of appetite or emaciation, he should cause the discontinuance of its use at once.

The treatment of the skin manifestations is similar in all respects to that of the simple eruptions of the same varieties. Systemic poisoning should be treated symptomatically, since we have no specific.

DR. JAMES NEVINS HYDE.—In one case I have met with a bullous type of eruption. This occurred in a young man who had been subjected to an operation for necrosis of the tibia. His recovery was slow, and during the time there were constant recurrences of a rash upon the surface of his body, for which he finally consulted me, and for a time I was quite at a loss to know its cause. The eruption occurred in the form of large areas of erythema, which at first were of a bright color, afterwards becoming dull. Conspicuously over this surface were scattered large bullae filled with a clear transparent fluid, which, when ruptured, left a superficially excoriated surface. An examination of the dressings showed that iodoform was used. When this was stopped, the eruption disappeared in the course of ten or twelve days and did not reappear.

DR. JAMES C. WHITE.—I have seen a number of cases of iodoform poisoning resulting from its free use in cases of surgical injuries. I have never seen any systemic manifestations of the effects of iodoform in those cases in which it has caused dermatitis. The form of dermatitis has varied from simple hyperæmia up to the vesicular form usually stopping there. In some cases there has been a furuncular condition possibly due to the mechanical action of the particles of iodoform. The inflammation of the skin is almost always found in the vicinity of the part to which the iodoform has been applied. In cases where the gauze dressing is not used and the powder remains easily detached, it is possible to have affection of the skin in other parts from the transference of the powder from one portion of the body to other portions.

A CLINICAL STUDY OF ERYSIPELAS IN CHILDREN.

By DR. I. E. ATKINSON, of Baltimore.

Erysipelas was defined as a contagious, infectious disease. It has not yet been positively determined whether the affection is due to one specific organism, or whether it may be produced by one of several different micro-organisms. It was thought by the speaker that the disease as it occurs in children, offered some special opportunities for the solution of this question. During the first month of life, erysipelas is an extremely fatal affection, but the mortality gradually diminishes up to the end of the first year. It may be that the fatality of the affection in the early period of life is to be explained by its dependence upon the poison of puerperal fever. The detailed histories of three cases were reported. In two of these cases a board-like induration occurred as the result of intense œdema and cellular infiltration. In

neither of these cases, however, was there suppuration. The speaker held that erysipelas should be considered as the expression of the effect of one of a number of specific causes, and in this sense should be regarded as a symptomatic inflammation.

DR. JAMES C. WHITE.—The author has alluded to the contagiousness of erysipelas. I would ask if he ever knew of a case directly contagious? Did he ever see two cases in private practice, in which there was evidence showing that the disease had been communicated from one to the other? In the description of one of his cases he referred to the use of the tincture of the chloride of iron. Was that given for the purpose of producing a specific effect?

DR. I. E. ATKINSON.—I have no personal experience with reference to the contagiousness of erysipelas, but I could refer to a number of cases in literature. In my experience, iron has had a more favorable influence over the course of erysipelas than any other remedy. I can not say that it is a specific.

DR. J. C. WHITE.—I have never seen a case of facial erysipelas transferred from one individual to another. If at all contagious, it must be so with extreme rarity. I regard the tincture of the chloride of iron as well as all other internal remedies as useless in the treatment of facial erysipelas. For five years I have given no internal remedies in the treatment of this affection, and I have never seen a case in which the eruption did not disappear within five to ten days.

In my limited experience, infantile erysipelas has seemed so wholly unlike in its clinical aspects, and its course with or without treatment, ordinary erysipelas as we see it not only in adults, and also in children after the earliest infancy, that it seems quite a distinct disease.

DR. JAMES NEVINS HYDE.—I have scarcely any experience with erysipelas occurring in the lying-in room, but I have had this experience which may serve to answer one of Dr. White's questions. A young mother, soon after confinement, had her ears pierced for earrings, shortly after this a typical erysipelas began spreading from the ear over the face and scalp. In a short time the nursing baby contracted the disease and, at the time that I was called in, it presented a typical erysipelas spreading over the face, from which it died.

DR. I. E. ATKINSON.—Nearly all cases of facial erysipelas, in children over one year and in adults, recover, so that these cases are not suitable for testing the effect of any special line of treatment. But in those cases where the erysipelas is associated with internal inflammation, or in what may be called septic cases I have no doubt that iron is beneficial. In these cases, it is not to be given in small doses, but in doses of half a drachm and even one drachm, three or four times a day.

DR. WHITE, of Boston, read a paper.

AN INTRODUCTION TO THE STUDY OF THE INFLUENCE OF DIET IN THE CAUSATION AND TREATMENT OF SKIN DISEASES.¹

DR. J. N. HYDE.—I have another article to add to Dr. White's list, and that is oatmeal. Dr. White has stated that the majority of patients might take the articles which he named without injury, and the same remark would apply to oatmeal. I have under observation a young woman who will invariably have, in the course of a few hours after the ingestion of oatmeal, without any addition to it, a facial efflorescence which is decidedly marked. This occasionally extends to the hands.

There is another article which I have had occasion to place on the blacklist, and that is what is known as the "seedless orange." I have met with a

¹ See page 409.

number of cases of urticaria which I attributed to the ingestion of this article. The eruption, generally of an urticarial nature, which I have seen following the use of grapes, I have attributed to the fact that the skin and seeds were also swallowed.

DR. E. B. BRONSON.—I fully agree with the author that very few of these forms of food which have been claimed to cause skin eruptions have any specific action. The effect of these articles is often due to the fact that they are unaccustomed articles of food. I should like to allude to one class of cases, and that is cases of skin affections in newly-arrived immigrants. I find that it is quite a common occurrence to have erythema or urticaria in this class of subjects, and for this I have suggested the name "urticaria of immigrants." This condition occurs in a large proportion of the cases in immigrants from Ireland, but I also see it in those coming from Germany and other countries. I have been inclined to attribute the affection to the great change in the diet, and direct these patients to return to the diet they had been accustomed to use before coming to this country.

DR. E. WIGGLESWORTH.—With regard to oatmeal I think that in many cases it is a question of cooking. If the grain is not sufficiently cooked, it will induce gastritis and diarrhoea and we may, as a result of the reflex irritation, have urticaria. This being scratched may cause eczema and thus we get eczema secondarily although not due to the specific effect of the oatmeal. It seems to me that in the case of maritime people, the salt air may have some effect in inducing eczema, and that the condition is not to be attributed to the eating of fish.

DR. G. H. ROHÉ.—While it is unquestionable that certain articles do produce effects upon the skin by disturbing the digestion, yet it is an undoubted fact that certain articles, such as crabs and oysters, produce effects upon the skin more frequently than do certain other articles which are more apt to disagree with the digestion. I know of no article so readily digested as raw oysters, and yet these do occasionally produce urticaria. I do not agree entirely with Dr. White with reference to buckwheat meal. I have seen pruritus follow the use of this article, but probably in these cases the quantity had something to do in inducing the condition. I do not think that anything taken with the buckwheat cakes, produced the irritation.

DR. P. G. UNNA.—In considering this subject we must distinguish between those articles which act on the skin after being taken into the stomach and being assimilated, and those to which the effect is due to a nervous influence. I have seen cases where patients have simply taken strawberries into the mouth without swallowing them and yet have had urticaria. In regulating the diet of a patient, I try to find out by a careful series of inquiries what articles seem to aggravate the disease from which he is suffering and then exclude these.

DR. L. D. BULKLEY.—There are other articles which I think might properly be added to the list given by Dr. White. I know of more than one patient who cannot take raspberries without suffering from urticaria. I know of others in whom pineapples have a similar effect. There is one article that has not been spoken of and that is milk. I have found that where milk is taken between meals it often does harm, whereas it can be taken with the food without injury. There is still another article which must be added to the list. I find that in acne, soup taken with the food makes the condition worse and this article has been left off the dietary with great advantage.

A paper read was by Dr. E. B. BRONSON, of New York, presenting a Classification of Diseases of the Skin.¹

THE TREATMENT OF LEPROSY.²

By DR. P. G. UNNA, of Hamburg.

DR. P. A. MORROW.—I am surprised and at the same time gratified to

¹ See page 371 and 427 of this Journal.

² See page 381 of this Journal.

hear such good results reported from purely local treatment. I have recently had the opportunity to see quite a number of cases of leprosy in the hospitals of Paris. These cases have been treated on the same general plan that we are accustomed to in New York, and that is, by the internal administration of chaulmoogra oil, from 90 to 200 drops per diem, divided into three doses. I believe that in some cases the leprosy manifestations are just as responsive to the influence of chaulmoogra oil as are the manifestations of syphilis to mercury. I have in the Charity Hospital a Norwegian who is the subject of tubercular leprosy. Under the influence of this treatment and the use of local applications the tubercles have disappeared, and he is apparently well. At one time I used caustic potash on a number of the nodules on the face, and they disappeared very rapidly. There is this to be said, however, that all cases are not equally responsive to chaulmoogra oil. Some are entirely refractory. Strychnia has also been employed in these cases, but it has been thought to be of little service.

DR. P. G. UNNA.—In one case I also used chaulmoogra oil, but in these cases I desired to test the efficiency of the external treatment. I shall now combine the internal and external medication.

THE PRESIDENT.—In my experience in the treatment of leprosy I have found the use of strychnia of service. The first subject on which I tried this remedy was a young man from Bermuda, who was suffering from the disease to such an extent that he was unable to dress himself. He was placed on a preparation containing strychnia, and within six weeks he was engaged at rowing a boat across the river. In almost every case where the *nux vomica* was used in sub-acute cases with no evidence of erethism, benefit has been obtained. I am in the habit of giving the strychnia in doses as full as the patient will bear it. After a few weeks, its use must be discontinued. I then substitute for it chaulmoogra oil, from one to three drachms in divided doses during the day. I also employ in connection with the internal use of *nux vomica* the external application of chaulmoogra oil. In those cases where the condition of leprosy is present, strychnia is decidedly contra-indicated.

DR. P. A. MORROW.—I did not mean to be understood as saying that I had personally found strychnia of no value. The drug has been largely experimented with in the French Hospitals and its use has been abandoned.

SALT IN DERMAL HYGIENE AND THERAPEUTICS.¹

By DR. H. G. PIFFARD, of New York.

DR. J. C. WHITE.—I am rather surprised that the author did not find more evidences of irritation produced by the strong salt solution. We know that workers in brine occasionally suffer from dermatitis. In pork and beef packers who use large quantities of salt, there is frequently seen inflammation of the skin affecting the hands and forearms, sometimes amounting to an impetiginous or furuncular eruption. It may be that in these cases the inflammation is due, not so much to the salt as to the other agents employed.

I have used salt in the form of ocean baths for certain cases of eczema. I have thought that they were of a special benefit in cases of erythematous forms of eczema, and also in the intertriginous forms.

DR. J. N. HYDE.—From some experiments that I have made, I am led to believe that the addition of an appropriate amount of salt to certain local applications would render them more efficient. I have met with certain cases of a severe form of eczema with pruritus which have seemed to have been relieved by the external use of salt and water. I have seen it applied in urticaria and have heard of its application in a form of rash met with in the alkali region. Some of these patients claim that they were immediately relieved of the pruritic sensations, when a solution of salt of the proper strength was applied.

¹ See page 421.

DR. E. WIGGLESWORTH.—I would ask if Dr. Piffard noticed any effect upon the growth of the hair?

DR. H. G. PIFFARD.—My observations in this respect were limited to my own person. I observed that the growth of hair upon the body was greater than it had been before. Whether or not this was due to the use of the salt solution, I cannot say. In regard to irritating effects from these saline solutions, I can only say that I have seen none. There has been no irritation except about the genitalia of females, and I have used it in a number of cases.

A CASE OF PURPURA WITH CIRCINATE LESIONS.¹

By DR. H. W. STELWAGON, of Philadelphia.

(To be Continued.)

NEW YORK DERMATOLOGICAL SOCIETY.

THE 174TH REGULAR MEETING.

DR. ROBERT W. TAYLOR, *President, in the Chair.*

DR. MORROW, presented a case of

PITYRIASIS RUBRA WITH PUSTULAR LESIONS OCCURRING IN A PSORIATIC PATIENT.

The patient, Frank Armstrong, was admitted to my ward in Charity Hospital one week ago. He has been in the past ten years a frequent inmate of the hospital on account of recurring attacks of psoriasis. His first attack was in 1876. Previous to this he had never had any skin disease. His general health has always been good; has no specific history. During the past five years he has been intemperate, drinking more or less all the time and occasionally indulging in a prolonged spree. At first his psoriatic attacks occurred at intervals of eighteen months to two years. More recently the intervals between them have been shortened and during the past five years he has had an outbreak every six months—usually in the fall and spring. He has been under my care a number of times. I have always found the eruption generalized and very characteristically developed upon the palms.

Three weeks ago he had, after a prolonged spree, what he at first supposed was another attack of the same eruption, but he noticed that the skin was intensely red over the entire surface, extremely itchy, and covered with white, flakey scales, which continually reformed. Upon admission the patient presented the characteristic appearance of pityriasis rubra. The skin was covered with large, dry papery scales, partly detached, and showing underneath a dry, red, shiny and non-infiltrated skin. The exfoliation has been abundant during the past two weeks.

The surface of the wrists, dorsum, palms of the hands and fingers was studded with innumerable pustules discrete and superficially situated. The same condition was observed upon the dorsum and soles of the feet and toes.

On my visit two days later these pustules had run together, forming a sort of subcuticular purulent exudation which entirely lifted up the epidermis from its bed. Two days later the entire epidermis was stripped off like a glove, forming a complete cast of the hands and fingers. The exfoliative process was not so advanced upon the feet, but to-night you will observe that the entire epidermis of the feet is loosened from its attachment and may be readily stripped off, leaving a red, shining, sensitive, but perfectly dry skin.

¹ See page 369.

This case, it appears to me, is interesting from two points of view. First, the development of pityriasis rubra in a psoriatic patient, the exfoliative dermatitis substituting, so to speak, the psoriatic outbreak which the patient had been accustomed to experience at this season for several successive years. So far as I am aware no etiological or pathological relationship has been traced between these two diseases which are assumed to be essentially distinct in origin and nature.

Second, the occurrence of distinct and well marked pustular lesions in connection with pityriasis rubra. The case presents certain analogies with a "case of pityriasis rubra with vesicular lesions" which I presented before this society in April, 1886. In that case the vesicles occupied relatively the same situation but they did not become confluent, nor was there a complete exfoliation *en masse* of the epidermis of these parts.¹

DR. BRONSON thought that the case was a very instructive one. He had seen similar ones and, for that reason, did not think that the inflammatory symptoms could be regarded as the result of accident alone. He had observed the sudden outbreak of pityriasis rubra on old men who had suffered from psoriasis for many years, the disease running a rapid course, being unaccompanied by any thickening of the skin, and associated with a more or less plentiful desquamation of small branny scales. He could recall the case of a woman, who had never had any affection of the skin, becoming suddenly affected with a severe attack of pityriasis rubra from which she recovered entirely, but subsequently she developed a distinct psoriasis. Also that of a man who had been a patient in the Charity Hospital, and who suffered from an erythemato-desquamative affection situated on the backs of the hands, which could not be distinguished from a pityriasis rubra.

DR. ALLEN said he had seen the patient presented by Dr. Morrow, when he had psoriasis alone, and who, after having been on a protracted spree, would suffer from a dermatitis of the face and scalp. This dermatitis did not in any way resemble the one which he presents to-night.

DR. SHERWELL thought that notwithstanding all that had been said on the subject he did not believe that a true psoriasis palmaris et plantaris could exist, except in a few rare and exceptional cases, unless a specific dyscrasia were present. He had seen many cases of pityriasis rubra, but never one preceded by a psoriasis.

DR. PIFFARD stated that the case could in no way be regarded as an example of pityriasis rubra of Hebra.

DR. FOX has seen similar cases develop after psoriasis. He thought the terms pityriasis rubra and dermatitis exfoliativa had been used very loosely, and that a distinction should be made between them. He mentioned having seen a dermatitis exfoliativa, similar to the one on Dr. Morrow's patient which had occurred in an Irish woman. In the bed adjoining hers, a little girl was lying and she developed an identical affection, and after its subsidence psoriasis lesions appeared. Also another case which he had seen in consultation some years ago for psoriasis. Dr. Jackson had seen the same patient again this summer and found a diffuse universal redness of the skin accompanied by desquamation of large scales. From Dr. Jackson's description, he judged that the affection was similar in its nature to those he had previously seen and which he had always found curable. He could recall at present three cases of psoriasis, in which a sudden invasion of a diffuse general redness accompanied with exfoliation of large squamæ occurred.

¹Up to this date (October 13) the exfoliation from the entire surface of the body has steadily continued. The scales have become smaller, more branny, less abundant; over the region of the chest the diffused redness has faded out, leaving here and there rounded reddened patches, resembling spots of psoriasis in process of involution.

Dr. ELIOT said that he thought that it was unscientific to include as one, such dissimilar affections as pityriasis rubra and dermatitis exfoliativa. The pityriasis rubra of Hebra had distinct characteristics, which could establish its want of identity with the dermatitis exfoliativa of Erasmus Wilson. He did not think that because redness and desquamation of the epidermis were present in two or more affections they should for that reason be regarded as parts of the same process, but that independent of these, the course and general features characterizing each should be considered. He thought that some of the cases mentioned to-night would come under the head of the *Herpétide exfoliatrice* of Bazin, and regarded Dr. Morrow's case as a dermatitis grafted upon a pre-existing psoriasis.

Dr. TAYLOR had seen cases similar to the one shown this evening occurring with psoriasis, Rhus poisoning, etc. He had formerly treated in Charity Hospital, the case which Dr. Morrow presented and considered the present manifestation as a dermatitis, which had developed on a psoriasis.

Dr. MORROW said that he was disposed to regard the condition shown by his patient as a pityriasis rubra. According to English and American authors no difference was recognized as existing between pityriasis rubra and dermatitis exfoliativa. If he were to make a distinction he should classify the latter as the acute state of the former, but he himself did not think that there were any well grounded clinical distinctions between the two. When in Paris this summer, Dr. Vidal had shown him a number of cases some of which were classed as pityriasis rubra and others as dermatitis exfoliativa. The clinical features were essentially the same in both. The accident of an unfavorable prognosis seemed to be the only basis of the differential diagnosis. He did not think we should accept Hebra's dictum that pityriasis rubra was necessarily a fatal disease. Dr. Morrow also regretted that attention had not been directed to the pustular lesions accompanying this case. They were with one exception quite unique in his experience.

Dr. PIFFARD spoke in regard to the difficulty of getting good photographs with artificial light. The trouble was due to deficient light, to the long exposure required—30" 45"—during which time absolute quiet was nearly impossible. He had, however, been making attempts and had succeeded in taking instantaneous photographs of *Leucoderma*, at 9 p. m. in his office. The photographs were shown to the society.

Dr. FOX showed some preparations for external use, consisting of various substances dissolved in the sulpho-oleate of sodium. He prefaced his remarks by referring to an ointment, which had been known under the name of polysalve. After many experiments Mr. Bague—pharmacist—had made the preparation exhibited this evening and had called Dr. Fox's attention to it. It was found that sulphur, chrysarobin, etc., was very readily dissolved in it, and that it was quickly absorbed by the skin. He thought it would prove more serviceable than ointments for a local application. He had found that equal parts of water could be mixed with it, and that a 2% chrysarobin 1-2% sulphur, and a 5% salicylic acid solution, which was perfectly clear and without sediment, could be made with it.

Dr. PIFFARD said that he had experimented with the old *oleum sulphuratum*, but had found it to be very irritating and not offering any advantages over other preparations in acne. He had also used a sulpho-oleate of sodium prepared from animal oils, *oleum morrhuae*, whale oil, etc. He thought that the combination of sulphuric acid and oil entered into the skin much better and more readily than oil alone, and though already containing some sulphur yet would take up more. In his opinion, the preparations presented by Dr. Fox would be found useful.

A CANDIDATE'S thesis on

“HYPERIDROSIS”

was then read by title, after which the society went into Executive session.

Correspondence.

DERMATOLOGY AND SYPHILOLOGY IN FRANCE.

The Sub-cutaneous Injection of Insoluble Mercurial Preparations.

PART SECOND; OBJECTIONS TO THE METHOD.

ALL the French Medical Journals gave the report of the meetings of the Medical Society of the Paris Hospitals. It is easily understood what must have been the feelings of our practitioners when they learned, upon the authority of the communications of M. Balzer that it was only necessary to make at intervals of from fifteen days to three weeks sub-cutaneous injections of calomel of the yellow oxide of mercury to free their syphilitic patients for a long time, if not forever, of the manifestations of their disease, and this without the least real inconvenience. When we think that there is scarcely a physician who does not treat several cases of syphilis during the year, that a knowledge of the treatment of the pox is not as widespread as it should be, that many do not know exactly what course to pursue nor what drug to employ, that they encounter real difficulties in causing their patients to take the remedies for a long time in the requisite daily dose, we find an explanation of the great favor with which the new method was received at once by both physician and patient. Physicians began at once to make injections of calomel among their private patients. Some syphilitics who had been refused this treatment by their physicians before the real efficiency and freedom from danger of the method had been confirmed by experience, have been known to seek advice from partisans who had been convinced of the worth of the procedure. In looking upon this infatuation, and in perceiving especially that the favor enjoyed by the injections was founded upon a fundamental error which tended to become more and more fixed in the public mind, viz ; that after the four or five injections required, one was for all time freed from his syphilis, Dr. E. Besnier thought it incumbent upon himself to interpose a reaction as speedily as possible against the current which was tending to entirely substitute for the older methods of treatment, the injection of insoluble preparations of mercury. This he did on the 25th of March, 1887, at the Medical Society of the Paris hospitals, by a communication which will become celebrated in the history of the treatment of syphilis, as a model of criticism, of logic, and of good sense.

Dr. Besnier begins by establishing that hypodermic injections of insoluble mercurial preparations, does not constitute, properly speaking, a new method of treating syphilis, which can destroy the syphilitic infection and radically cure the affection. That the injections are in reality only a particular mode of mercurialization. He had employed them experimentally in his hospital service since the first communication from Dr. Balzer, in 1886, at the Society of Biology. He was almost convinced of their excellence, but, unfortunately, observations since made, have caused a modification of his first favorable opinion. He has employed calomel in dose of ten centigrams suspended in about one gram and twenty centigrams of oil of vaseline,

that is to say, in the contents of a Pravaz syringe in ordinary use, and the yellow oxide of mercury in the dose of ten centigrams, suspended in a gram and twenty centigrams of gum water. He admits that the oil of vaseline is an excellent and useful excipient, but finds that the gum water is quite as good. I have already in a preceding letter pointed out the operative procedure of the physician of the St. Louis Hospital and will not revert to it. He believes from his experience with the method that the medium dose of calomel for injection at a given point should not exceed five centigrams. He makes two injections at a sitting, each representing five centigrams of calomel, one on the right side the other upon the left. If the symptoms have not become modified by the end of ten days' time he repeats the injections. He does not think that we can establish a fixed rule for the intervals between the successive injections of calomel. He has seen abscesses produced in women just as Dr. Balzer has. These abscesses have remained for from one to three weeks and produced severe pains, after which they have been cured leaving a violaceous plaque which did not disappear for a long time and left a depressed cicatrix. Patients who have had an abscess result from the injections, are particularly liable to have others follow subsequent injections. He believes that the gravity of these accidents is not great and that there is never need of surgical intervention. Dr. Besnier has only noted mercurial stomatitis and enterorrhœa in from four to five of the patients treated. He has, however, observed pains in the head and other parts, but these are cases of which it is impossible to give the exact origin. Passing to the consideration of the therapeutic value of these injections Dr. Besnier does not hesitate to declare that the theory of their action rests upon a pure hypothesis, *i. e.*, that the calomel becomes transformed into corrosive sublimate and thus slowly dissolves in the deep tissues; that it is then taken up again in the circulation, transported into the various organs and then eliminated; these changes continuing for a year. This, adds Dr. Besnier, is *the romance of the calomel injections*. Here is the reality. With forty centigrams of calomel we can only obtain twenty-three centigrams of corrosive sublimate, the rest being a residue of metallic mercury. In admitting even that all the calomel is utilized, it would only make a milligram of the bichloride per day to combat the syphilitic poison in the whole mass of tissues of the body. The truth is that the soluble portion of the drug is used up in a few weeks' and all its really curative action ceases. The infinitesimally small quantity of mercury which is found in the urine after several months comes exclusively from the very slow transformation of the residue of metallic mercury left in the tissues. The effects of the injections of calomel and of the yellow oxide of mercury are not in reality more rapid or more profound than those of the other methods of mercurialization. They do not succeed in causing true syphilitic plaques to disappear, but they must be acted upon in addition by local applications.

They rapidly triumph over superficial exanthematic syphilides but not over the secondary neoplasm, such a syphilitic lichen. Finally the adenopathies persist, which indicate that the general infection is not at all suppressed. All facts then point out that recurrences are to be expected, and indeed they are observed quite frequently. Out of fifty-three cases, Kopp and Chotzen had thirteen recurrences. Dr. Besnier cites two facts from his own personal observation which are indisputable. In one of his patients twenty-six days after the last of the five injections of calomel, he observed a

persistent cephalalgia followed by coma, incomplete rigidity, especially upon the right side, locking of the jaws, a large bed-sore, etc.—all the symptoms of syphilitic meningitis, which disappeared quite rapidly under the influence of daily doses of four grams of the iodide of potassium injected into the stomach. This case of meningitis of the highest gravity coming on with an unheard of rapidity in the full period of secondary syphilis, following the sub-cutaneous injection of thirty-eight centigrams of calomel, can only cause reflection and inspire in practitioners a wise reserve. It is not yet then permitted us to say, adds Dr. Besnier, that, hypodermics of insoluble mercury have made a great impression on practice. Physicians can not be persuaded to employ them. Local effects which are annoying are observed, and in certain persons may betray the existence of syphilis from their long persistence, and particular localization, and it is possible that more general accidents may be produced of which the existence is suspected but not yet sufficiently demonstrated. The yellow oxide of mercury, appears, it is true, to have less inconveniences attending its administration, but Dr. Besnier believes it less efficacious than calomel. This procedure for the purpose of mercurialization is not according to this author more practicable than others, even in hospital practice. Outside patients do not return for the injections, and those within the hospital leave when this treatment is begun, finding it too painful. He remarks, that it is often necessary to prolong anti-syphilitic treatment over several years—can we cover our patients during all this time with needle pricks? In this case all persons in close relationship with these patients would perceive their condition. The method must be rejected in ordinary cases; and we should not employ it when it is desired to act quickly and forcibly, for then, mercurial frictions, calomel in small dose, injections of soluble mercurial preparations are much preferable. The only real indication for hypodermic mercurialization by the insoluble preparations, is confined to the rebellious cases of syphilis and to its unusual manifestations. After an argument so cautious and vigorous nothing remains to be said. The syphilographers who convened at the Society of the Paris Hospitals to take part in the discussion upon the treatment of syphilis, have touched upon other points of this vast subject, and have all agreed with the criticisms of Dr. Besnier, upon the injection of insoluble mercurial preparations. Their unanimity in combating the procedure without the least restriction was remarkable; according to Dr. Martineau (meeting of the 22d April, 1887), these injections produce abscesses, have only a slow curative effect, and it is impossible to introduce them in private practice.

According to Dr. Mauriac (meeting of May 27, 1887), the curative effects of the injections of calomel are not superior to those obtained by the internal administration of the salts of mercury. He says "I have not found, up to the present time, any advantage in this method and it presents if not dangerous or of a serious nature, at least quite sufficient inconveniences to prevent me from adopting it; it does not at all prevent recurrences." Here the speaker cited a personal observation quite convincing. "It seems to me that one fact such as this and others which I might relate are quite as demonstrative as the general and vague assertions in which they tell us that we have no recurrences after the sub-cutaneous injections, or that we have less than with other methods, I maintain that they are quite as frequent, at least, this has been my experience in the trials I have made." Dr. Mauriac admits, however, that these injections act at times with very striking rapidity in overcoming

ing the syphilitic manifestations. For himself he cannot regard as serious the question of how much mercury should be injected to cure the syphilis, the doses are so evidently variable according to the case, that it is ridiculous to attempt such an estimate. He is convinced that the hypodermic method in which soluble or insoluble salts are employed will always remain an exceptional method.

Dr. Hallopeau (meeting of June 10, 1887) accepts all that Dr. Besnier had said regarding the injections of calomel. "These injections" said he "have at times provoked abscess formation, and this fact alone should according to my judgment suffice to cause their rejection as a usual method. The consecutive pains are further so intense as to cause the patients to hesitate about continuing the treatment. We have met with the same inconveniences from the injections of metallic mercury in emulsion of oil according to the procedure of Lang."

Dr. Vidal (meeting of June 24, 1887), has not wished to experiment with the method of Scarenzio and Smirnoff. He does not see plainly, *a priori*, what can become of the small allowance of calomel or of the yellow oxide of mercury injected into the tissues at periods more or less remote, without any justifiable rule for the lapse of time which passes between the injections. He has had occasion to see patients subjected to this treatment return after a brief delay with symptoms of syphilis of the most characteristic nature. Professor Fournier, from whom I asked his opinion on hypodermic injections of insoluble mercurial preparations, told me that from the first he was not a partisan and he gave me as a reason his objections which were identical with the objections made by Drs. Besnier and Vidal. Such is the exact statement as faithfully made as possible of the actual state of the question in France.

To sum up, we see that sub-cutaneous injections of calomel suspended in vaseline are ardently advised by Dr. Balzer as the best, the most practical and the most efficacious method of treating syphilis. These conclusions have been adopted without restriction by Dr. Guelpa experimenting in the service of Dr. Dujardin-Beaumetz at the Cochin hospital. But Dr. Guelpa had only treated five patients in this manner, and incompletely at that. His opinion and enthusiasm do not seem, then, to have a very great value. Dr. Du Castel in expressing serious reserves appears to be a partisan of the injections of the yellow oxide of mercury.

In opposition to the two young physicians of the Lourcine (Balzer) and of the du Midi (Du Castel) hospitals are the known syphilographers of the hospitals of Paris, who are resolutely opposed to the method and do not hesitate to declare it of limited practicability, moderately efficacious, and to a certain degree injurious. These are Drs. Besnier, Mauriac, Hallopeau, who have faithfully tried the injections in their service, and Drs. Vidal, Fournier and Martineau, who, according to the results already known, judge the method so little deserving that they have not even been willing to try it. The discussion upon the treatment of syphilis which has just taken place at the medical Society of the Paris hospitals has then had for result the demonstration that even with the perfections introduced by Dr. Balzer the method of injecting the insoluble preparations of mercury can not yet enter into current practice.

In fact, clinical good sense does not permit us to accept as convenient and really efficacious the methods of Smirnoff, which so many well known Germans have favored. Drs. Balzer and Du Castel have demonstrated that

in two or three weeks no further trace of the calomel injected was found, even at the point of injection. So that two or three weeks after the last insertion the reserve of the drug had become exhausted. That the economy may still be supersaturated with the mercury I can admit, but how long will this saturation last from soluble and easily eliminated drugs, which can no longer be replaced since the reservoirs no longer contain calomel?—No one would pretend to have forever purged the system of the syphilitic virus by this new procedure of mercurialization which can not, as Dr. Mauriac has well said, give to the mercury curative properties hitherto unknown. Recurrences are then to be feared, and the theory that they will occur is here unfortunately confirmed by experience. It would be necessary then, in order to make this method effective, to frequently renew the injections, but here local accidents intervene. Indeed, if four injections sufficed to cure forever an attack of syphilis, we could still, under certain circumstances, put up with four inflammatory nodes or abscesses and four indurated cicatrices as a result, although in many cases and especially in women these accidents are not to be disregarded, and for certain physicians their occurrence alone suffices to condemn the method. But if it is a question of causing similar lesions every month or every two months it is not to be dreamed of. Where is the patient either in or out of hospital who would consent during years perhaps to have painful nodes or abscesses in process of evolution. These inflammatory reactions render the method entirely inapplicable to the case of women, and for my own part I have witnessed the lamentations of a young female patient, who underwent four injections of calomel and who a few months afterward still presented indurated nodes. I will conclude then in saying that for the method to become really practicable we must succeed in suppressing almost all painful and inflammatory phenomena around the points of injection. So long as this result occurs the new procedure cannot enter into serious competition with the convenient means of mercurialization which we possess and which a long experience has taught us to know and to use knowingly. But if this result is obtained in some way (and we must recognize that the discovery of petrovaseline as an excipient is already a step in this direction) so that all serious accidents are suppressed, we must then fix the exact therapeutic power of the procedure and determine, so far as possible, the intervals of time at which it will become necessary to institute new series of injections. If these series are too numerous another objection may be raised that all the injections must be made by a physician, and frequent medical intervention in private practice is often a veritable impossibility. Many patients much prefer, either from taste or necessity, methods which permit them to care for themselves without going too often to the physician or giving rise to the least suspicions, and even if all these difficulties are set aside there will still be syphilographers who will prefer to prescribe a treatment which in case of accident they can immediately modify by increasing, diminishing or suspending, according to the circumstances. For as Dr. Besnier has well said I can not understand how it is found more exact or scientific to inject almost empirically and to leave in the tissues of a syphilitic a stock of calomel. I find it on the contrary infinitely more medical and more prudent to always hold the key, if I may use the expression, of a medication which the physician can never too closely direct and watch over.—

PARIS, L. BROCCQ.

EXTERNAL PERINEAL URETHROTOMY—CORRECTION.

To the Editor of the JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

DEAR DOCTOR—In your letter from Paris of July 22, 1887, published in your Journal, you speak of an external perineal urethrotomy, done by Prof. Guyon, on the 9th of July of present year.

Are you not a little in error, in the matter of attributing to Guyon priority in closing perineal sections with a view to primary union? In a paper which I read before the American Surgical Association in 1886 it will be found that I have been doing this operation since 1868. It is true the details of my operation differ from that of Guyon only in the manner of closing the wound still the object aimed at is the same, and the end achieved in some thirty odd cases has been perfect success. My first published article, with detail of cases to that date, was in *Gaillard's Richmond and Louisville Medical Journal* of 1872.

In not a single case have I had a failure, and every one of them has been successful. In this paper will be found a clear description of the operation which I have devised, and has given me entire satisfaction—it is a simpler method than that of Mr. Guyon.

I have taken the liberty of enclosing a copy of this paper to Prof. Guyon. If there is anything original in this operation, it surely is of American rather than French parentage.

I am faithfully and sincerely,

MOBILE, ALA.

C. H. MASTIN.

Selections.

ULCUS RODENS URETHRÆ.

UNDER the above name, Dr. Landaü, of Berlin (*Deutsche, Med. Zeitung*, No. 73, 1887), describes an ulcer of the female urethra, which is characterized by a decided tendency to persist, and is in all probability of a syphilitic origin, in so much as it heals under mercury or the iodide of potassium. The process is one of very slow progression, attacking, step by step, the walls of the urethra, spreading from the meatus where it takes its origin. It is conspicuous by an absence of any tendency to new formation or to spontaneous cure.

Another well marked characteristic of the urethral rodent ulcer, is, that it is located exclusively within the urethral canal. Pathologically we have in the cases which the author has recorded, the expression of a preceding inflammatory process. All the layers of the mucous membrane are filled with inflammatory cells, and here and there the superficial epithelial cells are necrosed. The author emphasizes the fact, that clinically, the symptoms are so slight in spite of the spreading of the lesion, that they escape the notice of the patient and the physician as well. As to treatment the author has found the employment of concentrated lactic acid to be the one means whose therapeutic worth must be recognized.

GOUTY ARTHRITIS.

GOUTY arthritis is not admitted by all authors. Dr. Turbure has recently published in his thesis a new observation which appears indisputable and he makes a study of the characteristics possessed by this form of malady. The discharge from the urethra in the gouty disease appears suddenly, is abundant and thick from the very first. The color and the nature of the discharge present the appearances of a blennorrhagia in its period of full development, the pus is greenish yellow, and progressively diminishes, little by little in consistence and quantity and disappears. The functional symptoms which accompany this arthritis are almost negative. There is almost complete absence of inflammatory reaction; neither redness, nor swelling of the meatus, no pain on passing water, no burning sensations in the canal, in fact, nothing to recall a classic gonorrhœa. In some cases, however, the pain appears to be quite severe. The prognosis in gouty arthritis appears generally favorable for having appeared at the end of the attack coincidently with the disappearance of pain, it rapidly disappears without the necessity of employing other measures than general treatment. *Journ. de Med et de Chir. Prat.*, Sept. 1887.

IS SYPHILIS A CAUSE OF GENERAL PARALYSIS?

SUCH is the subject of a thesis which Dr. Vernet has recently presented at Nancy. The author, following the example of several colleagues and with the aid of new arguments has endeavored to demonstrate that there must be some strong bond of union, some relation of cause and effect between syphilis and progressive general paralysis. He has established the fact that many general paralytics are the subjects of syphilis, and that in certain of them the syphilis appears to be the sole cause of the diffuse periencephalitis.

We conceive the possibility of meeting with diffuse sclerosis of the brain consecutive to syphilis, but specific lesions are more pronounced upon certain nervous territories, in other words, they have not everywhere and always a regularly progressive evolution since their point of origin may be a tumor or a region of specific alterations—consequently there will be some predominating manifestations according to the importance of the regions the most affected. Dr. Vernet has probably observed, as have we, a slight difference between the local and general symptoms. It is often this observation which leads to a search for syphilitic antecedents.

Dr. Vernet's work based upon fifteen carefully made observations, from quite a long experience and upon the arguments drawn from treatment, will be found of great interest to those making studies in the same direction. The author has well demonstrated the great influence of the iodide of potassium in general paralysis said to be of syphilitic origin and it is indeed the therapeutical results which have given him the strongest elements upon which to base his conclusions.—*Gazette des Hôpitaux*, Sept. 8, 1887.



Th. Clifford's case of Syphilitic Seborrhoea

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JOURNAL
OF
CUTANEOUS
AND
GENITO-URINARY DISEASES.

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VOL. V.

DECEMBER, 1887.

No. 12.

Original Communications.

SEBORRHŒAL ECZEMA.¹

BY

DR. P. G. UNNA, HAMBURGH.

WE are accustomed, at the present day to class as eczema all possible inflammatory conditions of the skin which are accompanied with vesicles, itching, and scale formation, and which produce the impression of a superficial dermatitis. I believe, however, few dermatologists heartily approve of this view of the disease. Many cases from beginning to end present only a papular eruption upon an erythematous base, with the subsequent production of scales, or possibly only scales are found upon a thickened, reddened skin. Such cases the physician calls dry eczema. This broadening of the conception of eczema to include a dry catarrh of the skin, I can in the abstract approve, but the various forms of eczema which remain constantly dry, or are only now and then moist, are so peculiar in other clinical symptoms that surely different disease processes must be separated, which have wrongly been classed together under the name of chronic eczema. In my private practice, and at the clinic, the simple diagnosis of "chronic eczema" has been interdicted. I do not content myself with

¹Abstract of paper read in the Dermatological Section of the Ninth International Medical Congress at Washington.

the hitherto simple expedient of the text-books, to name chronic eczema according to the region of the body upon which it has developed, at the same time considering it everywhere as one and the same pathological process, namely, eczema ; but both my assistants and myself hold it a duty to make the diagnosis of a precise and definite eczema only after a thorough examination of the patient has been made, and his history carefully taken.

I can assure you that, in a few months, the glance of any physician whose attention has been called to the typical distinctions between these various disease processes will become so acute that he will be in a position, at all times, to make these finer diagnoses. Take, for example, eczema of the face in infancy. My students are well aware that there are three absolutely distinct types of the disease to be distinguished—

1. A *nervous* eczema of dentition.
2. A tuberculous eczema.
3. A seborrhœal eczema.

If the eczema has not existed for a long time before treatment is begun, the diagnosis is usually made at the first visit.

A localization in the neighborhood of the eyes, nose, mouth or ears, complicated with phlyctenular keratitis, scrofulous rhinitis, otorrhœa, or a large vesicular type of eczema, with œdema and generalized swelling of the glands, with scarcely any itching, characterizes the tuberculous eczema, which permits of a prognosis of lupus and tuberculosis.

If, on the other hand, the neighborhood of the eyes, the nose and the mouth is free, so that the eczema surrounds the face like a mask cut out in the middle, we may have to deal with an eczema of dentition, or with a seborrhœal eczema. The first appears upon an entirely sound skin, usually upon the middle of the cheeks, and then upon the forehead, in quite a symmetrical manner, and almost always at the same time upon the radial side of the backs of both hands and upon the wrists, itches intensely, and the itching is the more pronounced the stronger the child, and the more healthy and sound the epidermis. It depends entirely upon reflex irritation, and especially that produced by the process of dentition, and disappears often coincidently with the eruption of a few teeth, as quickly as it came, probably to reappear in a few days. It resembles herpes zoster, in that groups of isolated, well-formed vesicles suddenly make their appearance upon a reddened base, but differs from it in its decided symmetry and its tendency to repeated recurrence.

Seborrhœal eczema is quite a different matter; here the skin was not previously quite healthy, and a few weeks after birth, there has existed, though often not so as to be noticed, an extensive seborrhœa of the scalp. This often spreads over the ears, forehead and cheeks after it has taken on a moist character, and, without attacking the neighborhood of the eyes, jumps over to the eye-lashes. It spreads upon the shoulders and upper arm in the form of dry, scaly or fatty plaques. This eczema maintains its fatty characteristics in all regions, even moist ones.

The itching is less than in eczema of dentition, but more than in the tuberculous form. And more readily than either of the others does it become a universal eczema, attacking next the genitals and spreading from here to the legs and back.

Just as we have various clinical types of the disease we have also a variety of methods of treatment, and hence the painstaking correct diagnosis has a great practical worth. In eczema of the nervous type it is recommended to paint upon the parts a zinc and ichthyol paste and to bind on a mask so that the child cannot scratch it off. At the same time appropriate internal treatment, such as the bromide of potassium, calomel, cocaine lotion for the mouth, etc. must be added, to allay the nerve irritation.

A more radical treatment may be instituted in tuberculous eczema, and as the itching is not so great the mask may be dispensed with. Here the ordinary white precipitate ointment and also ichthyol as an addition to zinc oxide salve are excellent.

In seborrhœal eczema an addition of sulphur to the zinc salve is found of benefit in all cases. Resorcin is also good, while ichthyol is here useless.

I would not be misunderstood as claiming to determine the origin of all cases of chronic eczema, but in eight or nine cases out of every ten it would be possible, and the remaining ones are such as have already existed for some time, or in which the clinical aspect and history of the case make it probable that we have a combination of two varieties of eczema. I will venture to present in detail to my professional colleagues these various types of eczema, and the future will show whether in this way a satisfactory classification of eczema is possible, and if this purely clinical distinction is rightly inspired.

I will to-day present at some length the clinical side of one of the most important of my types of eczema, viz., eczema seborrhœicum.

This designation has long been employed by me in place of the term dryseborrhœa (*Seborrhœa Sicca*), and I must refer, for details, to my article in one of the last numbers of the *Zeitschrift*, entitled "Was Wissen wir von der Seborrhœe?" For our present purpose it will be sufficient to give, in a word, as the result of my studies in this direction, that there does not exist any hypersecretion of the sebaceous glands, which can clinically, with justice, be considered as a so-called dry seborrhœa, due to a deposit upon the surface of firm products of the sebaceous gland. What have hitherto been classed together as seborrhœa are two entirely distinct and different things. First, we have a true fatty hypersecretion, which, however, does not proceed from the sebaceous glands, but from the coiled (sweat) glands.

This hypersecretion, the so-called oily seborrhœa (*Seborrhœa oleosa*), is poured out through the sweat pores, and should be regarded as a hydrosis, and indeed, designated hyperidrosis oleosa.

If we separate this form entirely, the group of so-called dry seborrhœa remains superfluous.

An exception is made in the case of vernix caseosa, which occupies a place by itself, and occurs only upon the fœtus. This is the product of a true hypersecretion of the sweat glands mixed with exfoliated epidermis. Secondly, I except for the present the so-called pityriasis tabescentium, since I have not, as yet, examined the disease microscopically. All other so-called dry seborrhœas, which I have had an opportunity to study microscopically, are chronic inflammatory processes of the skin, and nothing less than hypersecretions of the sebaceous glands. This especially applies to the pityriasis capitis, which leads to alopecia, and which I regard with Hebra as identical with seborrhœa capitis. Not in the sense that both are affections of the sebaceous glands, but for the reason that I recognize in both, clinically as well as histologically, only different forms of a definite inflammatory skin disease which, on account of a hypersecretion of the sweat glands, presents an abnormal abundance of fatty matter. This abundance of fat is not situated in the scales alone, as is generally believed, but it penetrates the whole thickness of the corium and epidermis, as in no other disease hitherto known. The lymph channels of the whole skin are injected with fat, and the production of fatty scales is hence a necessary and not at all surprising result.

The source of this fat cannot be from the sebaceous glands,

since they, according to the unanimous results of the investigation of Malassez, Schuchardt and myself, show no sign of hypertrophy or of an augmented activity, but, on the contrary, are choked up by abnormally compact masses of epidermis. That the true source of this abnormal fat is to be sought for in the coiled glands I can show by four histological facts; by the identity of the fat which is found in the cutis, the epidermis and the epidermic scales, with the fat of the coiled glands; by the inflammatory changes, hypertrophy and the signs of increased activity in the coiled glands; by the dilatation of the sweat pores within the thickened epidermic masses, and by the constant increase of the normal products of the coiled glands.

The starting point of almost all seborrhæal eczemas is from the scalp. Very rarely the affection begins with a corresponding affection of the margin of the eyelids, or upon one of the well-known surfaces rich in sudoriparous glands, such as the axilla, the bend of the elbow and the cruro-scrotal fold.

Upon the head it exists mostly as an affection of scarcely noticeable onset, and it is only after possibly months or years of existence that a sudden increase, a loss of hair, an unusual amount of scaliness or collection of crusts, severe itching, or, finally, a circumscribed moist spot, or an evident eczema, leads the patient to consult a physician. The affection begins then as a latent catarrh, the first traces of which manifest themselves by an agglutination of the epidermic scales which are thrown off in large lamellæ, and, further, as a faulty distribution of the skin's fat, in that the hair becomes abnormally dry from a closing up of the opening of the hair follicle, while the epidermis itself and the exfoliating scales become abnormally fatty (from the secretion of the sudoriparous glands).

From this point the process may take on one of three characters upon the scalp. Either the scaly masses may be simply increased in quantity, but remain white and only moderately fatty, while little by little an increase in the loss of hair is noticed, and the well-known and characteristic baldness of alopecia pityrodes appears, and the scalp becomes less and less movable in the regions which are growing bald. The scaliness decreases, and finally ceases entirely, when the scalp is quite bald, to make way for a hyperidrosis oleosa.

In another class of cases the scaliness so increases and persists, that during the whole duration it forms the principal symptom. The scales heap themselves up into fatty crusts between the hairs, which they cause to fall out. There is also a

corona seborrhoica, which gives a typical appearance to the patient thus affected. Later on the affection usually extends to the temples, over the ears to the neck, or skips over to the region of the nose and cheeks. In this form also a decided falling of the hair is frequently seen.

The third form is that in which the catarrhal appearances are the most pronounced, and in which "weeping" occurs, especially about that portion of the temporal region lying next to the ears, and following a simple pityriasis, with its attendant itching, tension and redness. The fatty scales are lost, and, as is always the case in eczema, the dark red, moist and shining basal horny layer comes into view. In increased weeping, erosions may appear at different points, and the rete be laid bare. Almost always the ears, or at least their outer edges, are affected, accompanied by œdema, swelling of the external auditory canal and the subjective symptoms usually present in all eczemas of the ears. In children, and especially infants at the breast while teething, the disease attacks the cheeks and forehead, because the habitual hyperæmia of these parts produces a favorable soil. The moist condition is not always present upon the whole scalp, and often a simple pityriasis or seborrhœa occupies the middle and posterior parts of the head, while the neck and face present the appearances of an eczema madidans.

The first of these three forms or grades of seborrhœal eczema is the ordinary pityriasis capitis, which usually slowly leads to alopecia pityrodes; the second is the so-called seborrhœa sicca capitis; and the third includes a large number of different affections which have heretofore been classed together as eczema chronicum capitis. I shall call these three forms, for the purpose of simplification, the scaly, the crusty and the moist.

Proceeding downward from the head we come to the next favorite spot for the eruption in the sternal region. Here the crusty form is found almost exclusively; much more rarely the scaly, when the hair grows thickly on the parts; and still rarer, the moist, in conjunction with a moist seborrhœal eczema of the whole upper portion of the body. The crusty eczema of this whole region has already been described by different authors as a distinct affection. So only recently by Colcott Fox, under Wilson's name of lichen anulatus serpiginosus, and by French writers as eczema marginatum. It has quite a characteristic appearance, and is, indeed, the most clearly defined form of seborrhœal eczema. Round or oval spots of the size of the finger nail are grouped together, partly coalescing, and hence forming

plaques about the size of a thaler, having a contour made up of segments of circles. A many-leaved variegated flower is thus suggested by the sharply defined outer border and the shadings of color.

Each patch is of a yellow color, and has an outer border of quite a fine red color when the scales are removed from it. This is the most common form of the affection in the sternal region when of slight development. We find it more often where there is a fat deposit upon the trunk and quite long hair is produced, than where the skin is soft, thin and hairless.

If the affection here assumes considerable dimensions, the point of departure changes into a yellow colored, quite smooth but slightly scaling center, about whose periphery fresh outbreaks of the eruption appear with the characteristic raised papules and yellowish white or yellow crumbling fatty scales of the original. At times this fresh eruption is irregularly distributed, and at times appears in the form of a bow with the convexity always towards the outer side. This last form of the affection is found mostly upon the back, and especially in the interscapular furrow.

In the axilla, on the other hand, crusts are almost never to be seen, and even the yellow color of the central portion of the patch is absent. There is a tendency here to assume the moist form, and to spread with the usual rapidity of an eczema over the thorax.

From the shoulders it spreads down upon the arms almost always in the crusty form, and seldom as a moist eczema. Here a decided predilection is shown for the flexor surface. This, and the tendency to appear upon surfaces in contact with each other, is explained by the rôle which the coiled glands play in eczema seborrhoicum.

The backs of the hands, and especially the backs of the fingers, are often affected with a moist eczema, when on the head appears a crusty eczema seborrhoicum, and a moist eczema occupies the regions of the ears and face, the trunk and arms escaping.

The affection takes on a peculiar form when it is localized upon the palms and soles. That it makes its appearance in these situations at all is of itself a strong argument that the affection is entirely independent of the sebaceous glands. Here are found little heaped up masses of scales corresponding to individual coiled glands, and resembling psoriasis guttata. Later the epidermis peels off and a geographical appearance is pro-

duced. There is no weeping. Upon the lower part of the trunk, the buttocks and hips, we mostly find the crusty form in rings and advancing in serpiginous circles leaving behind yellowish and later on brownish pigmented patches.

The cruro-scrotal fold and the approximating surfaces of the thigh and scrotum are favorite locations for the disease, which forms no small part of the conditions passing under the name of *eczema marginatum* of Hebra, which term undoubtedly includes at the present day a great variety of distinct germ diseases.

The thigh and extensor surface of the knee are but little affected, while the popliteal space and leg often are. At first we find here only the large papular and thick crusty forms.

I have reserved the face until the last, and until we had passed in review the principal forms found upon the body. Here we find the scaly form, when a beard is worn, as a diffuse pityriasis on the one hand, and on the other as circumscribed, somewhat reddened, exceedingly itchy patches in the moustaches and whiskers, but loss of hair never follows. In women the diffuse scaly form is rare; here are found mostly circumscribed scaly, yellowish or yellowish gray slightly elevated patches which, can often only be made out on careful examination. These patches occupy mostly the forehead, cheeks and naso-labial fold, and extend to the sides of the neck.

Red papules, from the size of a mustard seed to that of a pea, appear oftentimes upon the forehead, cheeks and nose in congestive conditions of the face. They are free from scales, or covered with fine yellow ones, and between the papules the skin becomes reddened, and causes a slight burning sensation. Unless cured, a true rosacea is developed from this beginning, and it is this form which I have named the *eczematous*. *Seborrhœal eczema* is indeed the most frequent cause of roseola in women, and many cases of roseola begin to improve the moment the causative *seborrhœal eczema* of the scalp is cured.

So in men the use of alcohol is frequently the remote, and an overlooked *seborrhœal eczema* of the head, the more direct cause of a rosacea.

Extremely seldom do young children have the thick, crusty form upon the face, but the fatty crumbling form of crust. Patches of *seborrhœa* are often seen about the mouth and nose in old people, which are well known to be the starting point of carcinoma (*Volkmann's Seborrhœal Carcinoma*).

The face is a favorite location for moist *eczema seborrhœicum*, especially in childhood, and only in adults when associated

with moist eczema of the neck and head. Itching is not severe. Versicles are never seen, but eczema rubrum is present so soon as the fatty crusts are raised from the surface.

The affection develops just as well in the Meibomian glands as in the coiled glands, and upon the eyelids is very obstinate. Usually the affection of the scalp has preceded it. The crusts are dry and fatty, and the lashes are seldom shed. Chronic conjunctivitis of the lids is often a concomitant affection. All these forms are found in the ear passages. In almost every case of eczema seborrhœicum of the scalp, a simple scaliness of the ear is observed, accompanied by dryness and itching.

Usually there is an abundant secretion from the coiled glands of the ear canal, *i. e.*, of the fat glands of the ear.

The rarer crusty form is usually transformed into the moist.

The nails are seldom attacked, but seborrhœal eczema may lead to the formation of verruca accuminata and condylomata.

Let us now look at the cause of the disease. Eczema seborrhœicum advances slowly from the periphery, and often years pass and a patch remains in the spot on which it has begun, giving rise to slight symptoms. Beginning upon the head, as a rule, its spread is downward over the ears, face, neck, sternum and inter-scapular furrow, and upon the arms. This choice of location is so characteristic of the affection as to be considered pathognomonic. No other eczema and no psoriasis has this course.

For the most part over large surfaces the skin is quite free, so that the tendency of the affection to assume disc and ring forms produces a variegated appearance. This is lost in certain rare cases, where, after many years' duration, the whole surface becomes literally covered over. In such cases it resembles pityriasis rubra, but is distinguished from it at the first glance, aside from the difference in odor, by the thickness, yellowish color, crumbling nature and fattiness of the scales, and, further, by its benignity.

Seborrhœal eczema ends after appropriate treatment in recovery, and does not cause relatively great itching. In the scaly and crusty forms the patients experience only slight itching, and occasionally slight pain at the periphery of the patch.

The differential diagnosis is to be made from other forms of chronic eczema, and from psoriasis, which latter disease the author has known to have been confounded with it by careful and able observers.

I can bear witness that this affection flourishes in Russia,

Scandinavia, England, Holland, France and North America, as well as in Germany, and the differential diagnosis between it and psoriasis is of great importance.

The points in diagnosis are: First. The spreading of the affection from above downward, mostly in the middle line of the body, and the stationary character of the lesions, while, in psoriasis, the spreading takes place from the elbows and knees, and more suddenly affects the whole body.

Second. The never failing previous history of a seborrhœal affection.

Third. The constant factors of the fatty and crumbling character of the scales, and the yellowish color of the whole affection.

Fourth. The peculiar configuration of the separate lesions, the thickened plaques spontaneously flattening out in the middle or on one side; the red color changing to a yellow, and the scaly surface becoming smooth, to suddenly again break out at the margin in a raised, red, scale-covered, bow-formed wall. The diagnosis of the disease upon the lower extremities must often be made from the accompanying lesions upon the upper portions of the body, because the peculiar yellow color of the affection is hidden by the cyanotic blue hue which masks all skin lesions in this situation.

It will be seen from these remarks on differential diagnosis that the correct diagnosis has a great influence upon the prognosis and therapy. The prognosis is more favorable than for psoriasis.

If a seborrhœal eczema, no matter of how great severity be cured, we have in the care of the scalp, or in some cases of the eyelids, a sure prophylactic against a recurrence of the disease upon other parts of the body.

A cure is not always easy because the deep-seated sweat glands are affected, but we have a number of excellent remedies, and I place sulphur before all other drugs, considering it almost a specific. In combination with zinc as a salve, salve mull paste or other fixed dressing, it is the best because it acts the quickest. It is especially praised in the moist forms, still it acts well in the scaly and crusty varieties, but still more rapid in their action in the latter forms, are chrysarobin, pyrogallol, and resorcin; while ichthyol is far less beneficial than sulphur. Salicylic and boracic acid have proven themselves valuable in combination with the above-mentioned reducing agents. On the other hand, Hebra's salve and the tarry preparations have an

unsatisfactory action. Even in the moist form the zinc-sulphur salve is far superior to the lead salve.

Internal remedies I have seldom found necessary. Arsenic prescribed by other physicians, I have found not to work quite so promptly in seborrhœal eczema as in psoriasis, although here a good effect is unmistakable. As local prophylactic measures at the point of origin, play the most important rôle after the cure of the disease, I am not much in favor of therapy by arsenic, since it might lead to neglect on the part of the patient of this prophylactic care of the skin and hair, without which arsenic would not prevent recurrences.

CLINICAL NOTES ON PRURITUS.¹

BY

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PRURITUS is such an exceedingly common condition, and occurs from so many causes, and in connection with, or as a symptom of, so many diseases of the skin, that it is doubtful if any one ever attained adult age without having at some time experienced the sensation of pruritus or itching. In many instances it has occurred as a momentary impression, from no recognizable cause, which has passed away spontaneously with or without relief being given by scratching. In other instances it has followed the sting or bite of an insect, irritating underclothing, or other local cause, and has quickly ceased with its removal. Still other cases of pruritus are caused by the internal use of drugs, as of opium, or are from irritating ingesta, or may be connected with some well recognized blood state as jaundice, or uremia, or dependent upon some nerve disease, and may be more lasting. In still other cases it is present as a symptom of a well recognized disease of the skin, such as eczema, lichen, urticaria or other cutaneous affection. Finally, in other instances it occurs as an independent, and often, apparently idiopathic, condition, sometimes of great severity, and persists, it may be, in spite of most careful and intelligent treatment, even to great suffering and, possibly, to the exhaustion of the sufferer.

¹Read at the Eleventh Annual Meeting of the American Dermatological Association, September 1, 1887.

In the present paper it is proposed to consider only the last named condition, namely, pruritus as a disease, and not as a symptom.

The expression "pruritus as a disease" is used with some little hesitation, for, in the present state of our knowledge, it is not at all possible to define or determine what the diseased or disordered condition is which determines the itching, nor, indeed, whether pruritus is not always simply a reflex symptom, due to some deeper disturbance, some instances of which are well established, and will occur to all.

But in Dermatological Literature pruritus has now come to be recognized as an independent affection, representing a functional disturbance of the nervous elements in the skin, without cutaneous lesions, except such as may be produced in the effort to obtain relief from the itching, or such as may be incidental, and in no way connected with the nervous phenomena. In this light the subject will be considered, although it will be seen that, in many of the cases here analyzed, the pruritus was not truly idiopathic, but was dependent upon causes which could be recognized with some degree of certainty. Perhaps the best definition of pruritus, considered as a disease, would be, *a functional disturbance of the nerve elements of the skin, resulting in itching, not dependent upon local lesions or local irritation.*

As is well known, the term prurigo was long confounded with pruritus, but, during later years, the former name has become restricted so as to represent a well recognized, though rare, affection, with clearly defined lesions of a papular character; the term pruritus has, therefore, come to be almost universally used to represent itching, either symptomatic or idiopathic, and, when used alone, most writers now agree to limit its meaning as defined above.

In looking over my notes of patients seen in private practice, I find records of eighty cases of pruritus of various forms and degrees among upwards of five thousand patients with miscellaneous skin diseases, or in nearly two per cent. of those applying for treatment. This would seem a very small proportion, and I have not been able to compare this ratio with that found in other statistics, but I can only record the proportion, as it appears, after a pretty careful search through my notes in private practice. I have not attempted to enter the subject in my public practice, and, quite possibly, the ratio would be larger there, as the number of cases would depend, in a measure, upon

care and accuracy in diagnosis. Undoubtedly very many more of these private patients may have experienced, and may have been treated for, pruritus, apart from any skin lesion, but the condition was recorded and treated alone as a disease only in the number mentioned. In a few of these patients some other disease of the skin was also present, and treated, either at the same time or on other occasions, but the pruritus maintained its identity, and was treated independently.

These cases may be classified according to their relative frequency as follows: Pruritus hiemalis, 36; pruritus generalis, 16; pruritus ani, 8; pruritus vulvæ, 8; pruritus scroti, 6; pruritus senilis, 6.

Of these patients thirty were females and fifty males. The ages varied from twenty-one, a female with an attack of pruritus hiemalis, to eighty-six, in a male with the same disease.

Over one-third of the entire number, namely twenty-seven, were between the ages of thirty and forty, the time of life when the nervous strain is the greatest, and when we would naturally expect to find such a symptom of nerve exhaustion as pruritus.

In a considerable number of the individuals there were recorded other symptoms of lowered nervous tone, and in the majority of cases there was either some well marked disease, such as gout, albuminuria, glycosuria, chronic bronchitis or other organic or functional disorder, or marked evidence of a general lowered vitality; some of these points will be referred to later on. We may now briefly consider the different varieties of pruritus under which these cases have been grouped.

Pruritus hiemalis. This affection has now come to be pretty generally recognized, and as seen in the statistics given, forms a considerable proportion of the cases of simple itching applying for treatment, thirty-five out of the eighty cases; of these twenty-three were males and twelve females. The longest duration was in the case of a gentleman aged thirty-four, who claimed that for twenty years he had had itching of the legs each year, with the advent of cold weather; several patients had had recurrences for ten years. A number of patients were seen in their first attack; one gentleman aged sixty-eight had had his first attack some ten to twelve years previously, the second about five years later, and the third five years later still. The month of beginning varied from October to January, and the cessation of the trouble was commonly stated to be in April or May. In a large share of the cases the location principally complained of was the extensor surfaces of the arms and legs, the thighs being most

commonly spoken of, and the upper arms next, and calves next. In a number of cases the whole body suffered considerably.

In some of the cases the itching had seemed to lose its winter character, and become continuous, but in the large majority, indeed in about all the cases here placed, the remission during warm weather was most pronounced. As is well-known, some of the English writers speak of this trouble as "winter *prurigo*," and describe also a "summer *prurigo*."

In regard to the existence of *pruritus hiemalis* as a distinct disease, a word may be said. There can be no question that in many persons we do meet with an itching of the skin, without primary lesions, occurring generally first and mainly on the extensor surfaces of the extremities, with the advent of cool or cold weather, and that this itching does tend to cease spontaneously as the temperature rises in the spring. But how far this *pruritus* is caused by any direct irritant action of the cold upon the nerves of the skin is by no means known, and my clinical studies in this affection lead me to believe that many elements have a bearing in these cases, which must be taken into consideration, in order to understand and treat the condition successfully; if regarded simply as a result of the action of cold on the tissues of the skin, little more than temporary benefit results.

A number of my patients exhibited marked evidence of a rheumatic tendency. There were also observed hay fever, nasal catarrh, bronchitis and other manifestations of delicacy of the skin and mucous membranes, and in certain others evidences of lowered nerve vitality; and indeed in few, if any, where the notes are sufficiently full, does the patient seem to be in as good health as would be found in the non-affected. I will grant that these elements of ill-health are not always so marked as to attract attention, and that very frequently the patient asserts that the health is perfect, and that the itching is the only wrong feature in the case. But I am confident, from experience, that a searching investigation will always reveal points of importance in regard to the case which will aid in its management and give suggestions for therapeutical action. The fact that of the multitudes exposed to cold, so few experience the trouble, points to other causes which predispose the individual to this affection. I am far more disposed to look upon imperfect action of the secretory glands of the skin as a cause, than to regard *pruritus hiemalis* as a purely neurotic affection, dependent upon an excitation of the nerves by cold. The action of the cold is rather that

of a disturbing agent, throwing extra work on internal organs, and occasioning the pruritus in a secondary manner from imperfect assimilation and elimination, as is seen in the itching of the skin accompanying kidney and liver disease.

The practical point of recognizing the points here mentioned lies in the therapeutical consideration of the disease. It has been stated by good authority that internal treatment is of no avail, and that local measures alone are to be recommended. In my experience, internal tonic and antacid treatment has been of much service in overcoming the tendency to relapse, while the local treatment commonly recognized has aided in giving relief to the present condition.

Pruritus generalis. Sixteen cases were recorded as pruritus, without any particular qualifications, they exhibiting various degrees of the condition, but all of them sufficiently severe to call for relief. In several of these cases, it is recorded that the patients had noticed a definite connection between the condition of the urine and the itching of the skin, and an examination of their urine at the time affected revealed abundance of urates or oxalate of lime.

In some of these cases, the itching seemed to begin with the cold weather, in previous seasons, but continued, or came so irregularly that the disease lost the winter character seen in the previous group, and so the case was excluded from pruritus hiemalis. In one case, that of a maiden lady aged fifty-eight, the first attack came about the time of the menopause, eight or nine years previous to her visit; the next attack was four or five years later, and the attack for which she applied for relief had lasted four months.

In a few of the cases, there seemed to be somewhat of an hereditary element, several members of the family being similarly affected.

Most of the cases presented little of interest, though in a few of them the gouty and rheumatic element was well pronounced.

Pruritus ani. This often most troublesome condition was recorded alone in but eight cases, although a large number of patients presented themselves complaining solely of pruritus, which proved to be due to eczema in greater or less degree or other complaints. One of these patients was aged twenty-five, four were between thirty and forty, and three between forty and fifty years of age.

In one case, that of a single lady, aged thirty-five, the disease

had lasted for twenty months, and had really exhausted the patient from the disturbed nights. The treatment, given by the physician calling the consultation, had been most excellent and judicious, and the measures subsequently advised were carried out carefully. But the case proved very rebellious, and during two and a-half months, while under observation, really very little benefit had been obtained. No cause could be ascertained for the itching.

One gentleman, aged twenty-five, had had an itching of the anus for eighteen months, which had been so severe that the sleep had been greatly broken thereby, in spite of assiduous treatment. Two elements appeared to have a causative relation to the disease, but unfortunately I did not have an opportunity to demonstrate their effect, as the case was only seen in consultation, and was soon lost sight of. One of these was tobacco, he being a smoker and a worker in tobacco, which I have repeatedly seen excite the trouble each time the patient was subjected to it; the other possible cause was a stricture of the urethra, which Dr. Bangs has, I think, conclusively shown to act as a causative element in certain cases, he reporting several instances of pruritus ani which were cured after a complete relief was given to an urethral stricture. I have not had opportunity of verifying the observation since my attention was called to the subject, but advised urethral treatment in the case under consideration, and allude to it in this connection that others, who meet such cases, may make trial of the same. We know that herpes pro-genitalis occurs more commonly in those who have suffered from urethral irritation, and is it not possible that the same urethral irritation may be reflected to the anus, as both are innervated by the same nerve, namely the internal pudic.

Pruritus vulvæ. This condition was recorded alone in eight cases, though, as in the instance of pruritus ani, many other cases, supposed to be this affection, turned out to be eczema, tinea cruris, or intertrigo. Six of these patients were fifty-four years of age or older, one forty-two, and one thirty-four years old. In two of them, aged respectively fifty-four and fifty-five years, the itching had begun at the menopause, about four or five years previously, and had lasted continuously to the time of observation. Most of the cases proved exceedingly rebellious to treatment.

Pruritus scroti. Six cases were recorded where the itching was confined to the scrotum, the youngest patient being aged nineteen, and the oldest seventy-nine years of age. One case,

quite remarkable for the severity of the itching and the distress occasioned thereby, was in the person of a man fifty-four years of age. He had always been exceedingly constipated, and had long depended upon laxatives and injections, his bowel troubles following an attack of yellow fever in 1847. He had had bleeding piles, which were entirely removed by operation eight years before his visit. Two months previous to his visit he experienced a sudden and severe attack of brachial neuralgia, with which he was confined to bed twelve days. This terminated in a pain in the second finger of the left hand, which remained at the time of the consultation. One month before his visit he was seized quite suddenly with a stinging or sticking pain beneath the scrotum, running forward. This was almost unbearable, and would last for hours at a time. The itching was so great that the desire to scratch was imperative, and he would yield to it necessarily. An attack came on while under examination, and the distress was evidently very great, the patient rubbing the hands together in agony. He stated that these attacks occurred many times during the day and night, sometimes as often as a dozen or sixteen times in the twenty-four hours, equally when the parts were covered and when exposed to air. When attacked, he was obliged to give up all else, the attention being completely drawn to the suffering part.

In one old gentleman, aged seventy-nine, who had had bladder difficulty for some months, which was being treated by a physician of eminence, a pruritus of the scrotum began about two weeks before the consultation. The main distress was along the raphé, although there was also some itching at the sides of the scrotum. It was suggested that the raphé be touched with pure carbolic acid, and when seen six months later, for another complaint, it was learned that this had been done five or six times, with the effect of completely removing the pruritus in a short time, he remaining free therefrom. The application burned considerably, but this was willingly borne by the patient, as I have repeatedly observed, for the relief given to the distressing itching.

In the case of the youngest patient with this trouble, a young man aged nineteen, the pruritus proved very rebellious, although, whenever suitable remedies were thoroughly used, there was a temporary relief; but the itching would return on any relaxing of the treatment.

Pruritus senilis. It is somewhat difficult to determine exactly how far the senile element of the skin should be recognized

as the cause of pruritus in any particular case, and whether the itching is ever due wholly to the structural changes known to occur in this organ in old age; some of the six cases recorded as of this nature may have had other causes as well, while in some of the cases of other varieties of pruritus in elderly persons this factor may also have had an influence. The ages of the patients were, respectively, 66, 70, 72, 77, 82 and 85 years; five were males, one a female. In almost all of the patients the pruritus proved troublesome, the relief produced by remedies being more or less transitory.

In looking over the clinical histories of the cases which have formed the material of this brief study, I confess that I am not a little disappointed at the actual results obtained in their treatment. Many, of course, were only seen in consultation, perhaps but once, and the results are not recorded. But in quite a number of instances I find that the disease proved very rebellious, that the itching had existed previously for years, and that often only a temporary benefit was obtained from the measures suggested, while in some cases there was really very little, if any, relief afforded by the treatment instituted. I do not think this can be attributed to a failure to apply the means commonly known and employed in these cases, for I have pretty diligently followed out the literature of the subject, and have sought to take advantage of the experience of others.

But it has occurred to me that we were too frequently at fault in the matter of regarding too closely the local condition in many of these cases, and neglecting to search for and discover the real cause of the complaint. I know from experience that this latter is often a most difficult matter, and that it frequently seems almost impossible to discover any tangible factor upon which to base a therapeutical course, other than the local condition calling for relief. But, on the other hand, all will agree that some cause must exist why one who was previously free from such a trouble should suddenly be attacked with an itching which makes life miserable, and from what we know in regard to certain causative elements, we may be led to infer that a reflex irritation probably exists in many more cases than is at first apparent. We know, for instance, of the itching of the nose and anus from the presence of intestinal worms, and, as previously stated, I think it more than probable that urethral stricture may occasion certain instances of pruritus ani. We know that itching occurs in connection with certain nervous affections, and that it is produced by the ingestion of certain

foods, and also by some drugs, as opium ; we know well of the itching and burning in urticaria, due to the presence of irritating food in the stomach and intestines, which in acute cases ceases at once on its removal. Other instances might be adduced in this connection to show how many of the forms of pruritus could be excited by some disorder, functional or organic, of other organs, and it is submitted whether more diligent search and more careful observation would not demonstrate this to be the case more frequently than is supposed, and consequently would be productive of more satisfactory therapeutic results.

Having my mind on this subject for a number of years past, I have been led at different times during the last ten years to record certain observations which I have made in regard to pruritic sensations experienced in my own person. I have recently collected some of the scattered notes, and offer the result as a slight contribution to the subject of pruritus, in a direction which, as far as I know, has not been previously touched upon in print.

Undoubtedly all have at times experienced the sudden sensation of itching or pricking pain in a part distant from that which was either injured, as by a pinch or a blow, or which was scratched to relieve a previous point of itching ; it is with reference to these secondary, reflex points of irritation that I would call attention, and offer the results of my personal observations.

I find scattered notes, in memorandum books and on slips of paper, relating to one hundred and twenty-three observations ; more than those were made, but the notes of them are lost, and in very many more instances the observation has occurred at times and in places where no record could be preserved. I may say that these investigations were not made systematically, but often at long intervals, and when the reflex sensation occurred I would at the time enter a brief note of it, wherever convenient. Very frequently the original point of irritation was occasioned by scratching or pinching for the relief of a momentary itching, and I would then occasionally try several other parts of the body to ascertain if the reflex could be excited. Occasionally the original point was irritated by a blow, or some accidental friction, and at times I have made trial of pinching a part perfectly healthy, without the existence of pruritus or other cause to call my attention to the part.

My earlier observations were made to ascertain if there was any crossed reflex, from one side of the body to the other, and

as I found, as will be mentioned, the reflex to be so uniformly unilateral, and moreover to appear in such different localities, even with the same local irritation, I continued recording my sensations as opportunity offered. I could wish that the observations were more numerous, and thought that I could find more notes, when I announced the subject of the paper. But they are sufficient in number to call serious attention to the matter of reflex action in connection with pruritus, and are offered in the hope that others will develop the subject as opportunities offer.

I may remark that the reflex sensation cannot always be produced at will, and I have a number of negative observations on record, where it is stated that one or more points of the surface were irritated, pinched or scratched, experimentally, without exciting the reflex sensation in question. I have thought that I have observed that the reflex could be most easily excited when I was in a tired or nervous condition, or when I was suffering from some of the effects of lithæmia, gouty sensations, etc., to which I am subject.

As stated, the total number of records which I have at hand amounts to one hundred and twenty-three, of which (why, I cannot tell) eighty-eight relate to the right side of the body, as the spot of primary irritation, and thirty-five were on the left. On all of these one hundred and twenty-three occasions the reflex occurred on the same side of the body as the point of irritation, except in *three instances*, as follows: first, inside of the right knee, reflex on *left* scapula; second, right thigh, four inches above the knee, reflex at insertion of *left* deltoid; and third, inside of right heel, reflex on *left* side of pubis.

The points of original irritation were on the right lower extremity in seventy-nine instances, left lower extremity twenty-two instances; right upper extremity five, and left upper extremity six times; right side of the trunk, four, and left side of the trunk seven times.

The points of local irritation and location of the reflexes covered almost every portion of the body, and were so varied that it is almost impossible to make any perfect analysis of them; but a few points of interest may be noted.

Certain locations seemed peculiarly susceptible to reflex irritation, and exhibited the sensation much more frequently than others. Thus, the scapula showed it thirty-four times, or more than one quarter of the entire number; of these, twenty-three were on the right side, from sixteen different points of primary irritation, and eleven on the left side, from nine primary points

The largest number of uniform reflexes from any single point was found here, it occurring six times from the middle of the thigh in its outer aspect, and four times from its front aspect; twice it occurred on the scapula from the inside of the knee, and twice from the dorsum of the foot. All the other instances were scattering, a single observation or two on each locality; in one instance, the *left* scapula showed a reflex irritation from the inside of the *right* knee.

The next most common locality in which a reflex was noted was on the back of the hand, where it occurred in sixteen instances, in fourteen of these from irritation at the upper and inner surface of the thigh, once from the front of the middle of the thigh, and once from the front of the knee.

Reflex irritation was observed at the insertion of the deltoid in seven instances, the point of primary irritation in all the cases being about the knee and thigh. The thorax, mainly the lateral portions, showed reflex irritation on nineteen occasions, from seventeen different localities, situated from the little toe to the region beneath the ear; and the nipple exhibited the reflex four times, from four different sites of irritation.

Considering now the points of original irritation, we find that the thigh was the primary site in fifty-five observations, and that the sensations were reflected to twenty-four different localities; of these reflexes nineteen were on the scapula, fifteen on the back of the hand, four on or near the clavicle, four at the insertion of the deltoid, and the rest scattering, including the wrist, middle of the forearm, elbow, shoulder, etc. The region of the knee furnished the site of primary irritation in twelve observations, the reflex sensation occurring in seven different localities; of these seven the scapula presented three, the elbow three, and two occurred at the insertion of the deltoid.

The feet and ankles were the seat of the original irritation in twenty-six instances, which was reflected to some twelve different locations: of these, the scapula presented seven, the trunk seven, the crest of the ilium two, the groin two, etc. Six instances of irritation on the toes showed a reflex, twice on the edge of the ribs, and once each on the nipple, lower angle of scapula, back and groin.

It would be useless to attempt to analyze further the facts here referred to, the number of observations is too few to afford any positive data in regard to the nature or course of these curious reflex sensations which are constantly occurring on the skin; indeed, those which have been alluded to show an amount

of confusion which it seems impossible now to clear up or explain. It is curious to remark that irritation in the same locality will frequently be followed on two different occasions by a reflex in quite a different locality, and that the reflex in the same point may be excited (though not at will) by irritation in quite different parts of the body.

While I have not been able as yet to establish any rules in regard to the occurrence of the reflex irritation on the different regions of the body, or to explain the occasion of pruritus as met with in practice, I trust that the subject has not been without interest to others as well as to myself, and believe that it will repay further study. It is in this hope that I offer these brief notes as a slight contribution to the subject, which may, I trust, stimulate myself and others to a renewed energy and zeal in studying cases of pruritus, with a view to determining the cause of its occurrence and its obstinacy.

Society Transactions.

THE NEW YORK DERMATOLOGICAL SOCIETY.

ONE HUNDRED AND SEVENTY-FIFTH REGULAR MEETING.

Dr. ROBERT W. TAYLOR, President, in the chair.

Dr. PIFFARD exhibited his new method of taking instantaneous photographs, by means of the flash from a pistol loaded with powdered magnesium wire. The negative taken was shown later in the evening.

Dr. BRONSON presented a patient, a boy ten years of age, with

“EXFOLIATIVE DERMATITIS FOLLOWING PSORIASIS.”

The entire trunk, neck, scalp and cheeks, together with a large portion of the extremities, were deeply congested and covered, more or less, with loosely adherent leaf-like scales. The desquamation was more pronounced upon the back and abdomen, where the scales were of considerable size, and, on removing the clothes, they fell in a shower upon the floor. On the legs and arms they were a little more adherent, but still could be easily rubbed off everywhere. On the extremities, the disease was less uniformly distributed than upon the trunk, occurring mostly in circumscribed patches. On the knees and the elbows the scales were somewhat firmer and more coherent than elsewhere. In the vicinity of the knees and below the more uniform redness of thighs, the disease extended in a multitude of fine miliary efflorescences apparently occupying the site of hair follicles. On most of the affected parts the skin was perceptibly thickened; the natural creases were deeper and wider apart than normal. The nails retained their normal lustre and smoothness, but showed numerous fine indentations.

It was stated that the disease had begun upon the extremities, especially in the region of the knees and elbows, about two years ago. At that time

the scales were thick, white and firm. About six months ago, the trouble began to spread over the whole body and finally came to cause the patient great discomfort, by reason of the stiffness of the skin and the impairment of motion, so that it was difficult and painful to dress and undress. When first seen by Dr. Bronson, which was about a fortnight ago, there were a number of spots, especially about the extremities, which were unmistakably psoriatic. The scales were adherent and when scraped off left a smooth red mucous surface, which presently displayed numerous small bleeding points. The case was presented as a dermatitis exfoliativa occurring as a sequel or complication of psoriasis.

DR. PIFFARD, in discussing the case, stated that he would call the case dermatitis exfoliativa, but not pityriasis rubra of Hebra.

DR. MORROW stated that not infrequently pityriasis rubra or dermatitis exfoliativa began in separate patches, which finally became confluent. He recognized the similarity of Dr. Bronson's case to the one presented by him at the last meeting of the Society, except that it was not so universal, and besides in this patient there was an infiltration and thickening of the skin which had not been present in his case. He further stated, that the patient which he had presented, had within the last few days almost entirely ceased exfoliating, the redness had cleared up, leaving pigmented patches here and there, very suggestive of psoriasis in process of involution.

DR. BRONSON stated, that he regarded his case as an exfoliative dermatitis connected with psoriasis, and not having anything to do with pityriasis rubra. He also said, that exudative symptoms were sometimes present in psoriasis. He had seen patches of weeping and even suppuration in connection with it.

DR. BRONSON also presented a case of

"ANOMALOUS PIGMENTATION"

of the skin, in a man about twenty-eight years of age.

The patient had been treated some two years before, for a considerable period with mercury, and presumably for what was regarded as syphilis. At the time the case first came under Dr. Bronson's care, which was about a month ago, there were no symptoms either objective or subjective which could be considered as distinctly syphilitic. There had been much itching of the skin, attended now and then with a papular eruption. The papules that could be seen were fine, bright red in color, and occurred in small clusters. Such were found on the forehead, eyelids and legs. They disappeared very rapidly, and not in the manner of syphilitic efflorescences. About the legs, and especially below the knees, the surface was slightly scaly. Almost every where the skin appeared somewhat congested, and at the same time pigmented. Though the natural coloring of the patient was a medium tint, the hair being brown, the beard a light brown, the eyes blue, etc., yet the skin over most of the trunk was as dark as that of a mulatto. The pigmentation was very marked over the upper part of the arms below the axillae. On the back, the dark color was mottled, with numerous light spots scattered over it. When first examined, the cubital glands showed considerable enlargement. At the present time, this feature is barely perceptible, and the papules have also disappeared.

At the request of Dr. Bulkley, who was absent, Dr. Elliot presented for him a case of

MULTIPLE FIBROMA CUTIS AND MULTIPLE MOLLUSCUM FIBROSUM.

occurring in a man about thirty years of age, who had been referred to him

for treatment at the New York Skin and Cancer Hospital by Dr. Levisseur. Patient is rather stupid and can give no history in regard to his trouble, beyond the fact that he had first noticed its inception four years ago. When examined, it was seen that there were lesions present, which differed greatly in objective appearance, but he could not state which had been first observed by him. The mollusca fibrosa were scattered here and there without regularity over the trunk and extremities and varied in size from a pea to about a hazelnut. They presented their usual characteristics clinically and under the microscope. The other lesions, which were quite numerous over the body, were either only slightly raised above the surface or quite prominent. Their base was quite hard, circumscribed and deep-seated, while the skin over them was of a bluish tinge, soft and yielding. These lesions under the microscope were found to be hard fibromata, that is, these small tumors formed the hard base mentioned. Since the patient had been under observation a slight fluctuation in the prominence of the tissue, which was over these lesions and which projected above the level of the surrounding skin, was observed.

In the discussion, Dr. Sherwell stated that he had seen molluscum sebaceum followed by molluscum fibrosum. It seemed to him that the fibrous tumor developed on the site of a molluscum sebaceum as a result of irritation.

DR. TAYLOR thought that a fibroma was often present with molluscum sebaceum. Frequently an achroecordon resulted from atrophy of this latter.

DR. PIFFARD could not see how a molluscum fibrosum could follow a molluscum sebaceum. The latter was epithelial, and could not become transformed into fibrous tissue.

DR. SHERWELL said he had, however, seen fibrous tissues of considerable size remain after molluscum sebaceum, and which had still further increased in size.

DR. ELLIOT presented a case of

“PAPULAR SYPHILIDE,”

on account of its peculiar localization.

The patient could give no history of having had any trouble with his skin before. He stated that he had had connection with a woman five months ago, but not since. No venereal symptoms followed. He roomed with a friend from July 7, '87, to August 25, '87. This man had at the time a disease for which kalium iodatum and sarsaparilla had been prescribed, but as far as the patient could say, presented no objective symptoms of any disease. They were accustomed to smoke each other's pipes, and between three and four weeks after the patient ceased rooming with his friend, he noticed that the gum over over the right upper medium incisor was red, a little swollen and painful. The gum over the left incisor became similarly affected and the teeth loosened so that he pulled them out. Three weeks later the present eruption appeared. When first seen by Dr. Elliot there was a superficially ulcerated and ragged surface where the two teeth had been extracted, the gum was quite hard, red and swollen. There were many mucous patches on the lips and tongue. The cervical, submaxillary and cubital glands were enlarged, but not markedly so. On the body, the eruption had the peculiar localization, occupying the surface from the suprasternal notch above to the epigastrium below, and laterally it extended to the nipples on both sides. On the back the lesions were situated entirely along the spinal column from the

neck to the sacrum, but did not extend more than an inch on either side of it. There were a few papules on scrotum and on forehead.

DR. JACKSON presented a case of

“HEREDITARY SYPHILIS, DACTYLITIS.”

Patient J. 27 months old. There is no history of syphilis in the family, except that the father had had a “lump” on the neck some years ago. Child was perfectly clean when born and showed no symptoms of disease until the third month of life, when it had boil-like swellings on its right arm and a dactylitis on its left little finger. A gumma appeared on left forearm one year ago. Last summer it had snuffles and nose was sore. Now it has a gumma on left forearm, puckered scars on right forearm, dactylitis of left little finger, and protuberant frontal bones.

DR. CAMPBELL presented a case for diagnosis.

In O. R., a girl, 16 years old, was first seen as an out-patient about the middle of December, 1886. At that time she had a large but rather superficial ulcer just below the right knee. She was lost sight of until the beginning of October, 1887, when she came under Dr. C.'s treatment for an ulcerated lesion of the whole surface of the right buttock, the ulcer below the right knee having healed. In both instances the processes had involved the superficial and deep portions of the skin. The patient stated that she had been troubled with similar outbreaks for the past four or five years. The lesion first makes its appearance as a small papule, which becomes a pustule, and this healing leaves a scar or pit resembling that of a small-pox pustule. In some instances, the lesions coalesce and formed an extensive ulcer such as the one on the buttock. On examination of the extremities quite a number of inflamed papules and pustules are seen, and also many scars similar to those already mentioned. On the upper portion of the chest, near the median line, are two cicatrices about two inches in diameter, and on the under surface of the jaw is a red much depressed scar.

The patient is fairly nourished, and in other respects appears to be in good health. The teeth are not notched or irregular. As far as can be ascertained, there has been no syphilis in the family. Her treatment lately has been,

R Hydrarg. Bin Iod. gr. I
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 Infus. Gentian. Comp. ʒ IV
 Mix. Sig. ʒ I ter die.

and locally, iodoform ointment has been employed. Under this treatment she has improved very markedly

Dr. Campbell was inclined to consider the case as one of serofuloderma, and wished to obtain an expression from the members as to the nature of the lesions.

DR. ELLIOT presented a case of

“NAEVUS VASCULOSUS,”

in a baby five weeks old. It had been brought to the New York Skin and Cancer Hospital, Dr. Bulkley's service, on October 24th. The condition had been present since birth. The nevus occurs in uniform patches, and occupies the back, from the neck to the rump, the left pectoral region, the arms and hands, and the right leg.

The mother states, that while pregnant she took care of one of her

children who was suffering from tubercular abscesses and sinuses, and that she was often overcome by disgust.

The Society then went into Executive Session.

THE AMERICAN DERMATOLOGICAL ASSOCIATION.

(Concluded from page 439)

DR. R. B. MORISON, of Baltimore, read a paper on

LEUCOPATHIA UNGUIUM. A PECULIAR AFFECTION OF THE NAILS.

The ordinary white spots found upon the nails are well known, these are gradually forced to the outer edge of the nail by the growth of new nail behind. The time occupied in this process varies from four to six months. These spots are usually irregular in shape. The following case was described: A young lady, twenty years of age, recently came under the observation of the author, in whom these spots presented a uniform appearance. Examination of the nails showed white bands, one-sixteenth of an inch in width extending across the nails from border to border. The nails were perfectly smooth and in other respects normal. The general health was good, and there had been no acute disease within a recent period. These white bands across the nails had been regularly appearing for many months. During the previous summer the lines had disappeared almost entirely. The toe nails were not affected and the hair was not gray.

Portions of the nail were subjected to microscopical examination. Sections were made cutting the lines at right angles. By direct light these lines appeared of a pure white, while the rest of the section, was of a dark color. The application of acetic acid and other agents caused a gradual disappearance of the spaces. Canada balsam also caused their rapid disappearance. It therefore seemed evident that these white lines were due to air spaces in the nails, the disappearance being caused in the one case by the swelling of the adjacent cells induced by the acetic acid, and in the other, by the filling of the spaces with the Canada balsam. Microscopical examination of several of the ordinary white spots found on nails gave similar results.

OBSERVATION OF THREE CASES OF SIMULTANEOUS HAND AND FOOT DISEASE.

By DR. JAMES NEVINS HYDE, of Chicago.

CASE I.—The patient, a young man nineteen years of age, came under observation in May, 1887. The family history was good. He denied all specific disease. Three years previously he had noticed the first signs of the present affection which appeared upon the fingers and subsequently on the toes. The disease then extended to the palms of the hands and the soles of the feet, the local affection had gradually increased and he complained of the stiffness thereby induced. The free border of the nail was tilted away from the finger, and the space thus left was filled with hardened matter. The substance of the nail was rugous. He had recently noticed some sweating of the hands. The palms of the hands and the soles of the feet presented a condition of tylosis. The nails of the toes were tilted from the phalanges and presented a condition similar to that seen in the nails of the fingers. There was also bromidrosis.

CASE II.—The patient was a female aged twenty-four years, with good

family history. She presented tylosis of the hands and feet, which continually recurred. Careful examination showed her general condition to be fair. The pulse was unusually slow, being fifty per minute in the sitting posture. The hands were cold and bathed with profuse perspiration. The finger nails were somewhat rugous. The nails were tilted from the fingers and the spaces filled with grayish masses. The same condition existed in the toe nails. The palms of the hands and the soles of the feet were simultaneously involved, showing callosities. Every six or eight weeks there would be a reformation of the masses on the soles of the feet. Treatment had no apparent effect.

CASE III.—The third case was that of a male aged twenty-eight years with good family history and no history of syphilis. For two years he had noticed some numbness of the lower extremities, especially marked at night. There was an entire absence of hair on certain parts of the lower extremities. He stated that fifteen years before he had been struck on the head with a brick, and that a few years before coming under observation an operation had been performed upon the head, the exact nature of which he could not state. The hands and feet were habitually cold. Broad vertical areas, chiefly on the outer aspects of the limbs were found, in which not a single filament of hair could be detected. Two of the finger nails of the right hand showed marked vacuolations.

The above papers were discussed together.

DR. L. A. DUHRING.—I do not recall a case in which there was the regular distribution described by Dr. Morison. I have, from time to time, had under treatment cases in which the white spots called for treatment on account of the disfigurement produced. I have regarded these cases as resulting from a want of proper nutrition of the part, due to some defect of the nervous system. With this in view I have employed arsenic. Some of these cases have seemed to be influenced by the effect of long continued courses of arsenic, acting, as I think, through the nervous system, improving the nutrition of the whole member and of the finger and the nail in particular.

DR. P. G. UNNA.—With reference to Dr. Morison's paper, I would say that we know from the labors of various investigators that the presence of air in the horny tissues is always a secondary phenomenon. The horny masses must be changed before they will allow of the entrance of air. These white spots in the nails are analogous to medullary substance.

DR. R. W. TAYLOR.—I think that the cases which Dr. Hyde has described should be denominated cases of ordinary tylosis of the hands and feet. You will find this condition occurring idiopathically, without known cause; secondly, you will find it as the result of chronic eczema, and thirdly, it will be found as the result of chronic syphilitic psoriasis.

DR. LEGRAND N. DENSLOW.—With reference to treatment I would mention that in the last case which I had, I applied a saturated solution of salicylic acid in collodion until the whole mass came off. Then I made false soles for the feet with belladonna plaster spread on kid. In that way the patient, who is a hotel porter, is able to follow his occupation with comfort.

DR. L. D. BULKLEY.—I now have under treatment a somewhat similar case to Dr. Morison's in a lady thirty years of age. Her father had psoriasis and her sister has psoriasis. The patient herself is a sufferer from gout. From the family history I thought it possible that these spots might be due to gouty deposits in the nails, but I now think that in all probability they are due to the presence of air.

DR. E. W. WIGGLESWORTH.—In the treatment of these cases of tylosis, I find the greatest advantage from the application of a twenty per cent. mixture of salicylic acid with emplastrum saponis, continued until the cal-

losities are relieved. I then apply equal parts of belladonna and mercurial plaster spread on kid. I have also employed measures to improve the nutrition with good effect.

DR. G. H. TILDEN.—In connection with the paper of Dr. Morison, I should like to mention a case which I saw a short time ago. In this case two nails grew on the same finger, one above the other. One year ago the nail was destroyed by accident. The matrix had evidently been split into two halves, and each half of the matrix had produced a separate nail.

THE PRESIDENT.—The affection described by Dr. Morison is one with which, in its mildest form, we are all more or less familiar. The most marked case which I have seen came under my observation within the past few weeks. The case presents fully as large a proportion of leucopathies as the case reported, but they are not distributed as regularly. None of the lines reach entirely across the nail. Leucopathies of the nail are analogous to leucopathies of the hair, in which I have satisfied myself that the condition is due to fatty degeneration of the cells with the subsequent absorption of the fat. The fatty degeneration is shown by the application of osmic acid under the microscope. In the case of the nail, after the absorption of the cells which had undergone fatty degeneration, the horny nature of the tissue would prevent closure of the cavity, which would then remain filled with air.

DR. J. N. HYDE.—I would merely state that I first regarded these cases as examples of tylosis, but a more extended experience has shown me that this view was not correct. In one of the cases I have watched the course of the disease for three years. The parts have been macerated for days and weeks at a time. I know that there is a constant new formation of these masses. I know that the nails are undergoing a similar process. These cases are entirely different from the ordinary forms of tylosis and callosities.

DR. L. D. BULKLEY, of New York, read a paper entitled

SOME CLINICAL NOTES OF PRURITUS.¹

DR. E. B. BRONSON.—This subject with reference to the reflex effects of irritation, is an interesting one. In my own person I have irritated one point and observed a reflex effect in a distant point. It seems to me that this would account for many cases of secondary eczema, as occurs in those cases where an acute eczema of one portion of the body is accompanied by an eczema of some distant portion. We frequently see eczema of the thighs accompanying eczema of the scrotum.

I would say one word with reference to therapeutics. In the treatment of localized pruritus, especially of the anus, I regard carbolic acid as a most valuable remedy. This agent is usually not applied in a sufficiently concentrated form. I find in many cases of pruritus ani, with a certain amount of thickening, that a great deal of relief is afforded by the use of carbolic acid in the proportion of two drachms of the acid to one ounce of glycerine and water, or oil. I also often employ liquor potasse, using one drachm each of carbolic acid and of liquor potasse to the ounce. This is one of the most excellent applications, but it should, of course, be applied lightly.

DR. F. B. GREENOUGH, of Boston, read a paper on

CLINICAL NOTES ON PEDICULOSIS.

The speaker had found, taking the statistics for nine years, that the proportion of cases of pediculosis to the total number of cases of diseases of the skin was, in Boston, 5.5 %; in New York, 3. %; in Philadelphia, 3.33 %; Baltimore, 2.12 %; St. Louis, 1.5 %; Chicago, 3 % and Canada, 0.3 %. In 1884, New York reported out of a total of 2,737 cases of skin disease, no cases of

¹ See page 459.

pediculosis of the head. During the same year the number of cases of pediculosis pubis reported from Chicago equaled that reported from all of the other cities. The only explanation of this fact that can be offered is that the difference is more in observers than in the number of cases of the affection. An observer in one city may put under the head *eczema capitis* a case which would be considered in Boston as one of *pediculosis capitis*. The three different forms of pediculi are the *pediculus capitis*, the *pediculus corporis* and the *pediculus pubis*. These pediculi are rarely seen except in their own locality. The presence of pediculi capitis in large numbers causes cutaneous trouble. So far as the efflorescence goes, the *eczema* thus induced is identical with that due to other causes. The distribution and other conditions make the diagnosis easy. He had only in one instance noted the *pediculus corporis* on the skin and he thought it possible that they should feed without leaving the clothing.

DR. L. A. DUHRING.—With reference to the question whether the pediculi vestimentorum ever leave the clothing, my experience with a certain number of cases is that they do. I can recall a number of instances where the pediculi were seen feeding on the skin. The speaker referred to the use of carbolie acid ointment in the treatment of this affection. I would ask what is the strength of the ointment which he employs.

DR. GREENOUGH.—The strength of the ointment is from ten to twenty grains to the ounce. I have used it as strong as thirty grains to the ounce. This is sufficiently strong to kill the pediculi.

DR. J. C. WHITE.—I would say a few words with reference to the diagnosis from the position of the eruption. In the majority of cases, as has been stated, we look on the occiput for the characteristic efflorescences. I, however, see cases in which I can make the diagnosis without looking at the head at all. In children where you see around the mouth, the nostrils and the ears, the lobes especially, a characteristic form of *eczematous eruption*, the diagnosis can almost certainly be made of *pediculosis capitis*. This eruption in some respects resembles that of *impetigo contagiosum*.

In regard to the position of pubic lice, I would say that it is not infrequent to find them occupying the general surface of the body. This is especially apt to be the case in hairy men. This is an important practical point, as the treatment is often limited to the pubic region, and thus a certain number of the pediculi escape and the disease soon returns. A careful examination will often show the lice not only on the abdomen but also on the axillae and on the lower portions of the legs. In one case, I have found these lice in the eyebrows and in the hair of the head.

In the treatment of pediculosis of the pubic region and of the head I always use crude petroleum. Crude petroleum is not very inflammable, it being quite a difficult matter to light it. I find this always effective. It never produces the slightest irritation even on the most inflamed surface. It should be allowed to remain in contact with the hair for two or three hours.

DR. P. G. UNNA.—In Vienna, it is the custom to regard every case of pustular *eczema* of the scalp and neck as due to pediculosis. I have never believed this. I find the pediculi may come secondarily on the scalp. In many of these cases in which pediculi are found in connection with *eczema* of the scalp, the pediculi are present simply because they have found a good feeding ground.

DR. J. N. HYDE.—In the statistics, it will be observed that there is a great predominance of pediculosis of the pubes reported from Chicago. This can be accounted for. There is a certain class of individuals, sailors, etc., who, during the summer are engaged on the lakes, but who, in the winter, come to Chicago. They come under observation in the most vile conditions as the result of all kinds of debauchery, suffering from syphilis,

pediculi, etc. These cases multiply from contagion during the summer months, and in this way the large number of cases of pubic pediculosis from this section of the country is accounted for.

I have seen only one case in which they were located in the eyelashes. The treatment which I employ is crude petroleum.

DR. L. D. BULKLEY.—Attention has been called by Dr. Tilbury Fox to a little lesion made by the pediculus corporis by the insertion of its proboscis. He made the point that the proboscis was inserted into a follicle of the skin, and that on its removal a small hemorrhagic spot was left. I think that I have seen this on a number of occasions, and I should like to know whether or not others have laid any stress on this as a diagnostic point.

The PRESIDENT.—With reference to the pediculi vestimentorum, it seems to me that they must leave the clothing to feed upon the skin. They certainly will feed upon the skin if placed there. Some years ago I collected a number of the pediculi and kept them in a bottle, and from time to time allowed them to feed upon the skin and watched the result. I was able to verify the statements of Dr. Tilbury Fox with reference to the insertion of the sucker. This is not a sharp cutting instrument, but is dull, and is inserted into a follicle. After its removal, there remains a minute droplet of blood, which, in the course of a few hours, becomes black. I regard this as a diagnostic point of considerable importance. This is, in fact, the only sign of pediculosis corporis except the scratch marks, and the latter may not be present for the first few days.

In the treatment of this condition crude petroleum seems preferable to kerosene.

THE DIAGNOSIS OF DERMATITIS HERPETIFORMIS.

By DR. L. A. DUHRING, of Philadelphia.

The chief characteristic of the affection is the multiformity of the lesions manifested in the natural evolution of the disease. If a given case remain sufficiently long under observation, multiformity of lesions will sooner or later be noted, and this will repeat itself. Blebs, vesicles and pustules may appear together or separately. Mixed eruptions are the most common, vesicles predominating. In one attack or another only one kind of lesions may be present. The disease presents clearly defined characters in distinct elementary lesions, and certain distinctive abortive lesions. Secondary forms of lesions also exist. Pigmentation of a dirty yellow or brownish hue and variegated is usually a marked feature in chronic cases. Excoriations from scratching with thickening of the skin usually exist. In no other affection are such varied combinations of lesions met with as in dermatitis herpetiformis. Erythema and vesicles, or vesicles and blebs, or blebs and pustules frequently exist side by side in close proximity with more or less pigmentation, excoriation and secondary changes. Itching is usually a most distressing symptom, and is most severe in the vesicular variety. In the pustular form subjective symptoms may be wanting. The disease is extremely chronic, extending over a number of years.

Some cases of dermatitis herpetiformis closely resemble cases of erythema multiforme, but the lesions of the former disease are less sharply defined and the course of the two affections is different, erythema multiforme being an acute disease of short duration. The disease occasionally resembles herpes iris, but the chronicity of the affection would exclude herpes iris; the lesions are also more virulent and accompanied with a more profound degree of cutaneous disturbance. Herpes iris is a benign affection, running an acute course and terminating in recovery, although subject to relapses. When the bullous varieties exist alone they may resemble pemphigus vulgaris. The com-

bination with other lesions will, however, prevent any confusion in the diagnosis.

With reference to the term dermatitis herpetiformis, the author stated that he had adopted it in preference to dermatitis multiformis for the reason that there was already a disease named erythema multiforme, and the use of the term dermatitis multiformis might lead to confusion and give rise to the opinion that it was simply an advanced stage of erythema multiforme.

DR. J. C. WHITE.—This subject has been before the society in other relations, so that I shall now consider it simply from the standpoint of the diagnosis. We now see these causes not infrequently, and the question arises where were they before our attention was called to them? The answer is evident. They were diagnosed as erythema multiforme, as pemphigus and as hydroa. I do not suppose that any one would have classed them as herpes. I think that this term herpetiformis is a misnomer. This term suggests to my mind a distinct type of cutaneous change, but in the affection described by Dr. Duhring I see nothing relating to herpes. The term multiformis seems to me to be the proper one to apply to this affection on account of its constant variability and protean character.

DR. L. D. BULKLEY.—I wish to briefly mention a case which shows some of the difficulties in diagnosis. The patient entered the hospital with a remarkable skin lesion which was regarded as dermatitis herpetiformis. There was almost general alopecia. The patient had fever and the temperature remained high until his death. At the autopsy we found generalized sarcoma. The lymphatics in the groin were enlarged and various internal organs were involved. Whether the cutaneous lesions were manifestations of the internal disease or not, I cannot say.

In regard to the diagnosis of dermatitis herpetiformis, I think that the duration of the case and the history of recurrences are the most important points. Where the patient is seen in the first attack it is difficult to make the diagnosis. I think that there is such a disease as dermatitis herpetiformis, and under this head we have been able to place a certain number of cases which we should be at a loss to place under any other head.

THE PRESIDENT.—I cannot help thinking that Dr. Duhring has included in his description cases of quite different nature. It seems to me that these cases are analogous to the old hydroa, to cases of septicæmic origin and possibly to cases of local origin. It seems unphilosophical to regard these different cases as examples of a certain definite disease. I think that in certain cases we may find the grouping of lesions described as characteristic of dermatitis herpetiformis, resulting from local irritants or from the bites of poisonous insects.

DR. F. B. GREENOUGH.—I would ask what portions of the body are most likely to be affected in this disease, and whether or not it may come on any part of the body?

DR. L. A. DUHRING.—The eruption may appear in any part of the body. In the communication I presented this morning I was compelled to leave out many interesting points. I omitted all reference to etiology. I need hardly say that we are on the threshold of our investigations with reference to this subject. Five or ten years will throw a great deal of light upon the questions which are presented by it. In most of my contributions with reference to this disease, I have dwelt largely on the clinical features of the affection. As time goes on I shall take up the question of etiology. In regard to the name, *I will say that I am no stickler for a name.* I have suggested the term herpetiformis for the reason already stated.

THE USE OF MEDICATED RUBBER PLASTERS IN CERTAIN CUTANEOUS DISEASES,

By DR. H. W. STELWAGON, of Philadelphia.

The speaker had employed rubber plasters containing a certain per-

centage of various substances, such as chrysarobin, pyrogallie acid, ammoniated mercury and oxide of zinc. The special field of these plasters is in the treatment of certain chronic affections, such as sluggish patches of eczema, psoriasis, callosities and ringworm. A ten to twenty per cent. plaster of salicylic acid is useful in the treatment of callosities. In the treatment of lupus vulgaris the effect obtained from the pyrogallie acid plaster was equal to that obtained by the use of the ointment. Chrysarobin plaster has been used with advantage in ringworm. The application may be allowed to remain in position one or two weeks.

DR. P. G. UNNA.—In the plasters which I have employed, the plaster mass is spread upon muslin much more flexible than that on which the rubber plaster is spread. The adhesive material which I have employed has been either the oleate of aluminium or the best India-rubber. As little of the adhesive material as possible is employed, not more than two to five grammes to the square metre. The strength of the plaster is reckoned not by percentage but as so many grammes of the active agent to the square metre.

TWO CASES OF TYPICAL IMPETIGO SIMPLEX.

By DR. L. A. DUHRING, of Philadelphia.

Considerable skepticism exists concerning the existence of a distinct disease entitled to the name impetigo simplex. Impetigo is one of the rarest of cutaneous affections. The following cases were reported:

CASE I.—A boy aged four years, and well nourished, was brought to the author, with the history that two weeks previously he had some itching, and this was followed by the appearance of white lumps. Shortly after this pustules formed. They appeared a few at a time, lasted several days and then dried up; at the time of observation there existed about two dozen lesions upon the fingers, toes and legs. There were typical pustules of the size of a split pea, raised about one line above the surface of the surrounding skin. They were seated upon bright red, non-indurated bases. They were discrete and manifested no tendency to group. Microscopical examination did not reveal the presence of any micro-organism. The process ran its course in about three weeks, no local or internal treatment being employed.

CASE II.—A boy aged four years, perfectly healthy, presented a discrete pustular eruption which had appeared seven days previously. Twenty or thirty small pustules with a slight areola were found. These were most marked on the fingers and toes. The pustules had thick walls and showed no tendency to rupture. There was no itching. The disease terminated in spontaneous cure in two of three weeks. The disease in neither of these cases appeared to be contagious.

In the absence of the author, the Secretary read a paper entitled
A PROTEST AGAINST EXCESSIVE STRENGTH OF LOCAL APPLICATIONS
(OFFICIAL AND OTHER) IN SKIN DISEASE,

By DR. SHERWELL, of Brooklyn.

At the business meeting the following officers were elected:

President, DR. I. E. ATKINSON, of Baltimore.

Vice-President, DR. P. A. MORROW, of New York.

Secretary and Treasurer, DR. G. A. TILDEN, of Boston.

The report of the committee on the Congress of American Physicians and Surgeons was received and adopted. Dr. I. E. Atkinson, of Baltimore (with Dr. G. H. Tilden as alternate), was appointed as representative to the Executive Committee of the Congress.

The Society then adjourned to meet at the call of the Council.

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